

physician believed Medicare was likely to deny payment for the specific service; and

(ii) The beneficiary (or someone eligible to sign for the beneficiary under §424.36(b) of this chapter) signed a statement agreeing to pay for that service.

(e) *Criteria for determining that a physician knew that services were excluded as not reasonable and necessary.* A physician will be determined to have known that furnished services were excluded from coverage as not reasonable and necessary if one or more of the conditions in §411.406 of this subpart are met.

(f) *Acceptable evidence of prior notice to a beneficiary that Medicare was likely to deny payment for a particular service.* To qualify for waiver of the refund requirement under paragraph (d)(2) of this section, the physician must inform the beneficiary (or person acting on his or her behalf) that the physician believes Medicare is likely to deny payment.

(1) The notice must—

(i) Be in writing, using approved notice language;

(ii) Cite the particular service or services for which payment is likely to be denied; and

(iii) Cite the physician's reasons for believing Medicare payment will be denied.

(2) The notice is not acceptable evidence if—

(i) The physician routinely gives this notice to all beneficiaries for whom he or she furnishes services; or

(ii) The notice is no more than a statement to the effect that there is a possibility that Medicare may not pay for the service.

(g) *Applicability of sanctions to physicians who fail to make refunds under this section.* A physician who knowingly and willfully fails to make refunds as required by this section may be subject to sanctions as provided for in chapter V, parts 1001, 1002, and 1003 of this title.

[55 FR 24568, June 18, 1990; 55 FR 35142, 35143, Aug. 28, 1990]

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AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 50 FR 12741, Mar. 29, 1985, unless otherwise noted.

### Subpart A—General Provisions

#### §412.1 Scope of part.

(a) *Purpose.* (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (organ acquisition costs incurred by hospitals with approved organ transplantation centers, the costs of qualified nonphysician anesthesiologist's services, as described in §412.113(c), and direct costs of approved nursing and allied health educational programs) is made on a reasonable cost basis. Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with §413.86 of this chapter. Additional payments are made for outlier

cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(2) This part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meets the conditions of §412.604.

(3) This part implements section 123 of Public Law 106-113, which provides for the establishment of a prospective payment system for the costs of inpatient hospital services furnished to Medicare beneficiaries by long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act, for cost reporting periods beginning on or after October 1, 2002. This part also reflects the provisions of section 307 of Public Law 106-554, which state that the Secretary shall examine and may provide for appropriate adjustments to the long-term care hospital prospective payment system, including adjustments to diagnosis-related group (DRG) weights, area wage adjustments, geographic reclassification, outlier adjustments, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(b) *Summary of content.* (1) This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems specified in paragraph (a)(1) of this section and sets forth the general basis of these systems.

(2) Subpart B sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems specified in paragraph (a)(1) of this section, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification.

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(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems specified in paragraph (a)(1) of this section.

(4) Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined under the prospective payment system specified in paragraph (a)(1) of this section.

(5) Subpart E describes the transition ratesetting methods that are used to determine transition payment rates for inpatient operating costs during the first 4 years of the prospective payment system specified in paragraph (a)(1) of this section.

(6) Subpart F sets forth the methodology for determining payments for outlier cases under the prospective payment system specified in paragraph (a)(1) of this section.

(7) Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(8) Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(9) Subpart K describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs is implemented for hospitals located in Puerto Rico.

(10) Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation under the prospective payment systems specified in paragraph (a)(1) of this section.

(11) Subpart M describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient capital-related costs is implemented effective with reporting periods beginning on or after October 1, 1991.

(12) Subpart O of this part describes the prospective payment system specified in paragraph (a)(3) of this section for long-term care hospitals and sets forth the general methodology for paying for the operating and capital-re-

lated costs of inpatient hospital services furnished by long-term care hospitals, effective with cost reporting periods beginning on or after October 1, 2002.

(13) Subpart P describes the prospective payment system specified in paragraph (a)(2) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation units effective with cost reporting periods beginning on or after January 1, 2002.

[66 FR 41385, Aug. 7, 2001, as amended at 67 FR 56048, Aug. 30, 2002]

### § 412.2 Basis of payment.

(a) *Payment on a per discharge basis.* Under both the inpatient operating and inpatient capital-related prospective payment systems, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as defined in § 412.4) is determined according to the methodology described in subpart D, E, or G of this part, as appropriate, for operating costs, and according to the methodology described in subpart M of this part for capital-related costs. An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that are extraordinarily costly to treat.

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) and the inpatient capital-related costs (as described in paragraph (d) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under subpart D, E, or G and under subpart M of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph include the following:

(i) Limitation of liability days payable under the payment procedures for custodial care and services that are not reasonable and necessary as specified in §411.400 of this chapter.

(ii) Guarantee of payment days, as authorized under §409.68 of this chapter, for inpatient hospital services furnished to an individual whom the hospital has reason to believe is entitled to Medicare benefits at the time of admission.

(c) *Inpatient operating costs.* The prospective payment system provides a payment amount for inpatient operating costs, including—

(1) Operating costs for routine services (as described in §413.53(b) of this chapter), such as the costs of room, board, and routine nursing services;

(2) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;

(3) Special care unit operating costs (intensive care type unit services, as described in §413.53(b) of this chapter);

(4) Malpractice insurance costs related to services furnished to inpatients; and

(5) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary during the 3 calendar days immediately preceding the date of the beneficiary's admission to the hospital that meet the following conditions:

(i) The services are furnished by the hospital or by an entity wholly owned or operated by the hospital. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.

(ii) For services furnished after January 1, 1991, the services are diagnostic (including clinical diagnostic laboratory tests).

(iii) For services furnished on or after October 1, 1991, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:

(A) Ambulance services.

(B) Maintenance renal dialysis.

(d) *Inpatient capital-related costs.* For cost reporting periods beginning on or after October 1, 1991, the capital prospective payment system provides a payment amount for inpatient hospital capital-related costs as described in part 413, subpart G of this chapter.

(e) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and are paid for on a reasonable cost basis:

(1) Capital-related costs for cost reporting periods beginning before October 1, 1991, and an allowance for return on equity, as described in §§413.130 and 413.157, respectively, of this chapter.

(2) Direct medical education costs for approved nursing and allied health education programs as described in §413.85 of this chapter.

(3) Costs for direct medical and surgical services of physicians in teaching hospitals exercising the election in §405.521 of this chapter.

(4) The acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organs) incurred by approved transplantation centers.

(5) The costs of qualified nonphysician anesthesiologists' services, as described in §412.113(c).

(f) *Additional payments to hospitals.* In addition to payments based on the prospective payment system rates for inpatient operating and inpatient capital-related costs, hospitals receive payments for the following:

(1) Outlier cases, as described in subpart F of this part.

(2) The indirect costs of graduate medical education, as specified in subparts F and G of this part and in §412.105 for inpatient operating costs and in §412.322 for inpatient capital-related costs.

(3) Costs excluded from the prospective payment rates under paragraph (e) of this section, as provided in §412.115.

(4) Bad debts of Medicare beneficiaries, as provided in §412.115(a).

(5) ESRD beneficiary discharges if such discharges are ten percent or more of the hospital's total Medicare discharges, as provided in §412.104.

(6) Serving a disproportionate share of low-income patients, as provided in

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§412.106 for inpatient operating costs and §412.320 for inpatient capital-related costs.

(7) The direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §413.86 of this chapter.

(8) For discharges on or after June 19, 1990, and before October 1, 1994, and for discharges on or after October 1, 1997, a payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

(9) Special additional payment for certain new technology as specified in §§412.87 and 412.88 of Subpart F.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 52 FR 33057, Sept. 1, 1987; 53 FR 38526, Sept. 30, 1988; 55 FR 15173, Apr. 20, 1990; 55 FR 36068, Sept. 4, 1990; 57 FR 33897, July 31, 1992; 57 FR 39819, Sept. 1, 1992; 57 FR 46510, Oct. 9, 1992; 58 FR 46337, Sept. 1, 1993; 59 FR 1658, Jan. 12, 1994; 59 FR 45396, Sept. 1, 1994; 62 FR 46025, Aug. 29, 1997; 63 FR 6868, Feb. 11, 1998; 64 FR 41540, July 30, 1999; 65 FR 47106, Aug. 1, 2000; 66 FR 39933, Aug. 1, 2001; 66 FR 46924, Sept. 7, 2001]

### §412.4 Discharges and transfers.

(a) *Discharges.* Subject to the provisions of paragraphs (b) and (c) of this section, a hospital inpatient is considered discharged from a hospital paid under the prospective payment system when—

(1) The patient is formally released from the hospital; or

(2) The patient dies in the hospital.

(b) *Acute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital that is—

(1) Paid under the prospective payment system described in subparts A through M of this part; or

(2) Excluded from being paid under the prospective payment system described in subparts A through M of this part because of participation in an approved statewide cost control program as described in subpart C of part 403 of this chapter.

(c) *Postacute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge

is assigned, as described in §412.60(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances:

(1) To a hospital or distinct part hospital unit excluded from the prospective payment system described in subparts A through M of this part under subpart B of this part.

(2) To a skilled nursing facility.

(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

(d) *Qualifying DRGs.* For purposes of paragraph (c) of this section, the qualifying DRGs must meet the following criteria for both of the 2 most recent fiscal years for which data are available:

(1) The DRG must have a geometric mean length of stay of at least 3 days;

(2) The DRG must have at least 14,000 cases identified as postacute care transfer cases.

(3) The DRG must have at least 10 percent of the postacute care transfers occurring before the geometric mean length of stay for the DRG.

(4) If the DRG is one of a paired DRG based on the presence or absence of a comorbidity or complication, one of the DRGs meets the criteria under specified paragraphs (d)(1) through (d)(3) of this section.

(5) To initially qualify, the DRG must meet the criteria specified in paragraphs (d)(1) through (d)(4) of this section and must have a decline in the geometric mean length of stay for the DRG during the most recent 5-year period of at least 7 percent. Once a DRG initially qualifies, the DRG is subject to the criteria specified under paragraphs (d)(1) through (d)(4) of this section for each subsequent fiscal year.

(e) *Payment for discharges.* The hospital discharging an inpatient (under paragraph (a) of this section) is paid in full, in accordance with §412.2(b).

(f) *Payment for transfers.* (1) *General rule.* Except as provided in paragraph (f)(2) or (f)(3) of this section, a hospital that transfers an inpatient under the circumstances described in paragraph

(b) or (c) of this section, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under subparts D and M of this part if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under subparts D and M of this part) by the geometric mean length of stay for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG payment.

(2) *Special rule for DRGs 209, 210, and 211.* A hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section and the transfer is assigned to DRGs 209, 210 or 211 is paid as follows:

(i) 50 percent of the appropriate prospective payment rate (as determined under subparts D and M of this part) for the first day of the stay; and

(ii) 50 percent of the amount calculated under paragraph (f)(1) of this section for each day of the stay, up to the full DRG payment.

(3) *Transfer assigned to DRG 385.* If a transfer is classified into DRG 385 (Neonates, died or transferred) the transferring hospital is paid in accordance with § 412.2(b).

(4) *Outliers.* Effective with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases that meet the criteria for cost outliers as described in subpart F of this part.

[63 FR 41003, July 31, 1998, as amended at 65 FR 47106, Aug. 1, 2000; 67 FR 50111, Aug. 1, 2002; 68 FR 45469, Aug. 1, 2003]

#### **§ 412.6 Cost reporting periods subject to the prospective payment systems.**

(a) *Initial cost reporting period for each prospective payment system.* (1) Each subject hospital is paid under the prospective payment system for operating costs for inpatient hospital services effective with the hospital's first cost reporting period beginning on or after October 1, 1983 and for inpatient capital-related costs effective with the

hospital's first cost reporting period beginning on or after October 1, 1991.

(2) The hospital is paid the applicable prospective payment rate for inpatient operating costs and capital-related costs for each discharge occurring on or after the first day of its first cost reporting period subject to the applicable prospective payment system.

(3) If a discharged beneficiary was admitted to the hospital before the first day of the hospital's first cost reporting period subject to the prospective payment system for inpatient operating costs, the reasonable costs of services furnished before that day are paid under the cost reimbursement provisions of part 413 of this chapter. For such discharges, the amount otherwise payable under the applicable prospective payment rate is reduced by the amount paid on a reasonable cost basis for inpatient hospital services furnished to that beneficiary during the hospital stay. If the amount paid under reasonable cost exceeds the inpatient operating prospective payment amount, the reduction is limited to the inpatient operating prospective payment amount.

(b) *Changes in cost reporting periods.* CMS recognizes a change in a hospital's cost reporting period made after November 30, 1982 only if the change has been requested in writing by the hospital and approved by the intermediary in accordance with § 413.24(f)(3) of this chapter.

[57 FR 39819, Sept. 1, 1992]

#### **§ 412.8 Publication of schedules for determining prospective payment rates.**

(a) *Initial prospective payment rates—*

(1) *For inpatient operating costs.* Initial prospective payment rates for inpatient operating costs (for the period October 1, 1983 through September 30, 1984) were determined in accordance with documents published in the FEDERAL REGISTER on September 1, 1983 (48 FR 39838), and January 3, 1984 (49 FR 324).

(2) *For inpatient capital-related costs.* Initial prospective payment rates for inpatient capital-related costs (for the period October 1, 1991 through September 30, 1992) were determined in accordance with the final rule published



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in the FEDERAL REGISTER on August 30, 1991 (56 FR 43196).

(b) *Annual publication of schedule for determining prospective payment rates.* (1) CMS proposes changes in the methods, amounts, and factors used to determine inpatient prospective payment rates in a FEDERAL REGISTER document published for public comment not later than the April 1 before the beginning of the Federal fiscal year in which the proposed changes would apply.

(2) CMS publishes a FEDERAL REGISTER document setting forth final methods, amounts, and factors for determining inpatient prospective payment rates not later than the August 1 before the Federal fiscal year in which the rates would apply.

[57 FR 39820, Sept. 1, 1992, as amended at 62 FR 46025, Aug. 29, 1997]

### § 412.10 Changes in the DRG classification system.

(a) *General rule.* CMS issues changes in the DRG classification system in a FEDERAL REGISTER notice at least annually. Except as specified in paragraphs (c) and (d) of this section, the DRG changes are effective prospectively with discharges occurring on or after the same date the payment rates are effective.

(b) *Basis for changes in the DRG classification system.* All changes in the DRG classification system are made using the principles established for the DRG system. This means that cases are classified so each DRG is—

(1) Clinically coherent; and

(2) Embraces an acceptable range of resource consumption.

(c) *Interim coverage changes—(1) Criteria.* CMS makes interim changes to the DRG classification system during the Federal fiscal year to incorporate items and services newly covered under Medicare.

(2) *Implementation and effective date.* CMS issues interim coverage changes through its administrative issuance system and makes the change effective as soon as is administratively feasible.

(3) *Publication for comment.* CMS publishes any change made under paragraph (c)(1) of this section in the next annual notice of changes to the DRG classification system published in ac-

cordance with paragraph (a) of this section.

(d) *Interim changes to correct omissions and inequities—(1) Criteria.* CMS makes interim changes to the DRG classification system to correct a serious omission or inequity in the system only if failure to make the changes would have—

(i) A potentially substantial adverse impact on the health and safety of beneficiaries; or

(ii) A significant and unwarranted fiscal impact on hospitals or the Medicare program.

(2) *Publication and effective date.* CMS publishes these changes in the FEDERAL REGISTER in a final notice with comment period with a prospective effective date. The change is also published for public information in the next annual notice of changes to the DRG classification system published in accordance with paragraph (a) of this section.

(e) *Review by ProPAC.* Changes published annually in accordance with paragraph (a) of this section are subject to review and comment by ProPAC upon publication. Interim changes to the DRG classification system that are made in accordance with paragraphs (c) and (d) of this section are subject to review by ProPAC before implementation.

[50 FR 35688, Sept. 3, 1985, as amended at 51 FR 31496, Sept. 3, 1986; 57 FR 39820, Sept. 1, 1992]

### Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

#### § 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b), (c), and (d) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid under the prospective payment systems specified in § 412.1(a)(1).

(b)(1) Effective for cost reporting periods beginning on or after January 1, 2002, covered inpatient hospital services furnished to Medicare beneficiaries

by a rehabilitation hospital or rehabilitation unit that meet the conditions of § 412.604 are paid under the prospective payment system described in subpart P of this part.

(2) CMS will not pay for services under Subpart P of this part if the services are paid for by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not to have CMS make payments to an inpatient rehabilitation facility for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees, as provided under part 417 of this chapter.

(c) Effective for cost reporting periods beginning on or after October 1, 2002, covered inpatient hospital services furnished to Medicare beneficiaries by a long-term care hospital that meets the conditions for payment of §§ 412.505 through 412.511 are paid under the prospective payment system described in subpart O of this part.

(d) Inpatient hospital services will not be paid under the prospective payment systems specified in § 412.1(a)(1) under any of the following circumstances:

(1) The services are furnished by a hospital (or hospital unit) explicitly excluded from the prospective payment systems under §§ 412.23, 412.25, 412.27, and 412.29.

(2) The services are emergency services furnished by a nonparticipating hospital in accordance with § 424.103 of this chapter.

(3) The services are paid for by an HMO or competitive medical plan (CMP) that elects not to have CMS make payments directly to a hospital for inpatient hospital services furnished to the HMO's or CMP's Medicare enrollees, as provided in § 417.240(d) and § 417.586 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 53 FR 6648, Mar. 2, 1988; 57 FR 39820, Sept. 1, 1992; 59 FR 45400, Sept. 1, 1994; 66 FR 41386, Aug. 7, 2001; 67 FR 56048, Aug. 30, 2002; 68 FR 45698, Aug. 1, 2003]

#### § 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified in

§ 412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in § 412.23.

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section and §§ 412.20(b) and (c), all excluded hospitals (and excluded hospital units, as described in §§ 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of hospital cost increases described in § 413.40 of this subchapter.

(c) *Special payment provisions.* The following classifications of hospitals are paid under special provisions and therefore are not generally subject to the cost reimbursement or prospective payment rules of this chapter.

(1) Veterans Administration hospitals.

(2) Hospitals reimbursed under State cost control systems approved under part 403 of this chapter.

(3) Hospitals reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)).

(4) Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

(d) *Changes in hospitals' status.* For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.

(e) *Hospitals within hospitals.* Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1):

(1) *Separate governing body.* The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

(2) *Separate chief medical officer.* The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(3) *Separate medical staff.* The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces bylaws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(4) *Chief executive officer.* The hospital has a single chief executive officer through whom all administrative authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive officer is not employed by, or under contract with, either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(5) *Performance of basic hospital functions.* The hospital meets one of the following criteria:

(i) The hospital performs the basic functions specified in §§ 482.21 through 482.27, 482.30, 482.42, 482.43, and 482.45 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both

hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals.

(ii) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of patients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for a period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in § 412.2(c). For purposes of this paragraph (e)(5)(ii), however, the costs of preadmission services are those specified under § 413.40(c)(2) rather than those specified under § 412.2(c)(5).

(iii) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(6) *Notification of co-located status.* A long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (e)(1) through (e)(5) of this section must notify its fiscal intermediary and CMS in writing of its co-location

within 60 days of its first cost reporting period that begins on or after October 1, 2002.

(f) *Application for certain hospitals.* If a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital as long as the hospital either—

(1) Continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 1995; or

(2) In the case of a hospital that changes the terms and conditions under which it operates after September 30, 1995, but before October 1, 2003, continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 2003.

(g) *Definition of control.* For purposes of this section, control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(h) *Satellite facilities.* (1) For purposes of paragraphs (h)(2) through (h)(4) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraphs (h)(3), (h)(6), and (h)(7) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

(i) In the case of a hospital (other than a children's hospital) that was excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the hospital's number of State-licensed and Medicare-certified beds, including those at the satellite facilities, does not exceed the hospital's number of State-licensed and Medicare-certified beds on the last day of the hospital's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For psychiatric hospitals, the requirements under § 412.23(a);

(B) For rehabilitation hospitals, the requirements under § 412.23(b)(2);

(C) For children's hospitals, the requirements under § 412.23(d)(2); or

(D) For long-term care hospitals, the requirements under §§ 412.23(e)(1) through (e)(3)(i).

(iii) The satellite facility meets all of the following requirements:

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

(B) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(C) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(D) It is serviced by the same fiscal intermediary as the hospital of which it is a part.

(E) It is treated as a separate cost center of the hospital of which it is a part.

(F) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(G) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period

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and using the same method of apportionment as the hospital of which it is a part.

(3) Except as provided in paragraph (h)(4) of this section, the provisions of paragraph (h)(2) of this section do not apply to—

(i) Any hospital structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the hospital continues operating under the same terms and conditions, including the number of beds and square footage considered, for purposes of Medicare participation and payment, to be part of the hospital, in effect on September 30, 1999; or

(ii) Any hospital excluded from the prospective payment systems under § 412.23(e)(2)(ii).

(4) In applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility if these changes are made necessary by relocation of a facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(5) *Notification of co-located status.* A satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(4) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period beginning on or after October 1, 2002.

(6) [Reserved]

(7) The provisions of paragraph (h)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, ef-

fective for cost reporting periods beginning on or after October 1, 2003.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 57 FR 39820, Sept. 1, 1994; 62 FR 46026, Aug. 29, 1997; 63 FR 26357, May 12, 1998; 64 FR 41540, July 30, 1999; 66 FR 41386, Aug. 7, 2001; 67 FR 50111, Aug. 1, 2002; 67 FR 56048, Aug. 30, 2002; 68 FR 10988, Mar. 7, 2003; 68 FR 34162, June 6, 2003; 68 FR 45469, Aug. 1, 2003]

### § 412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in § 412.1(a)(1):

(a) *Psychiatric hospitals.* A psychiatric hospital must—

(1) Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

(2) Meet the conditions of participation for hospitals and special conditions of participation for psychiatric hospitals set forth in part 482 of this chapter.

(b) *Rehabilitation hospitals.* A rehabilitation hospital must meet the following requirements to be excluded from the prospective payment systems specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2) and in Subpart P of this part:

(1) Have a provider agreement under part 489 of this chapter to participate as a hospital.

(2) Except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the following conditions:

- (i) Stroke.
- (ii) Spinal cord injury.
- (iii) Congenital deformity.
- (iv) Amputation.
- (v) Major multiple trauma.
- (vi) Fracture of femur (hip fracture).
- (vii) Brain injury.

(viii) Polyarthritis, including rheumatoid arthritis.

(ix) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(x) Burns.

(3) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program or assessment.

(4) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social or psychological services, and orthotic and prosthetic services.

(5) Have a director of rehabilitation who—

(i) Provides services to the hospital and its inpatients on a full-time basis;

(ii) Is a doctor of medicine or osteopathy;

(iii) Is licensed under State law to practice medicine or surgery; and

(iv) Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical-management of inpatients requiring rehabilitation services.

(6) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.

(7) Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment.

(8) A hospital that seeks classification under this paragraph as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient

population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated that population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(9) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1) or is paid under the prospective payment system specified in § 412.1(a)(2) for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population it actually treated during that period does not meet the requirements of paragraph (b)(2) of this section, we adjust payments to the hospital retroactively in accordance with the provisions in § 412.130.

(c) [Reserved]

(d) *Children's hospitals.* A children's hospital must—

(1) Have a provider agreement under part 489 of this chapter to participate as a hospital; and

(2) Be engaged in furnishing services to inpatients who are predominantly individuals under the age of 18.

(e) *Long-term care hospitals.* A long-term care hospital must meet the requirements of paragraph (e)(1) and (e)(2) of this section and, where applicable, the additional requirements of § 412.22(e), to be excluded from the prospective payment systems specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(3) and in Subpart O of this part.

(1) *Provider agreements.* The hospital must have a provider agreement under Part 489 of this chapter to participate as a hospital; and

(2) *Average length of stay.* (i) The hospital must have an average Medicare inpatient length of stay of greater than 25 days (which includes all covered and noncovered days of stay of Medicare patients) as calculated under paragraph (e)(3) of this section; or

(ii) For cost reporting periods beginning on or after August 5, 1997, a hospital that was first excluded from the prospective payment system under this section in 1986 meets the length of stay criterion if it has an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days and demonstrates that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in fiscal year 1997 have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

(3) *Calculation of average length of stay.* (i) Subject to the provisions of paragraphs (e)(3)(ii) and (e)(3)(iii) of this section, the average Medicare inpatient length of stay is calculated by dividing the total number of covered and noncovered days of stay of Medicare inpatients (less leave or pass days) by the number of total Medicare discharges for the hospital's most recent complete cost reporting period.

(ii) If a change in the hospital's Medicare average length of stay is indicated, the calculation is made by the same method for the period of at least 5 months of the immediately preceding 6-month period.

(iii) If a hospital has undergone a change of ownership (as described in §489.18 of this chapter) at the start of a cost reporting period or at any time within the period of at least 5 months of the preceding 6-month period, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the period of at least 5 months of the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required Medicare average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

(4) *Definition of new long-term care hospital.* For purposes of payment under the long-term care hospital prospective payment system under Subpart O of this part, a new long-term care hospital is a provider of inpatient hospital services that meets the qualifying criteria in paragraphs (e)(1) and

(e)(2) of this section and, under present or previous ownership (or both), its first cost reporting period as a LTCH begins on or after October 1, 2002.

(f) *Cancer hospitals—(1) General rule.* Except as provided in paragraph (f)(2) of this section, if a hospital meets the following criteria, it is classified as a cancer hospital and is excluded from the prospective payment systems beginning with its first cost reporting period beginning on or after October 1, 1989. A hospital classified after December 19, 1989, is excluded beginning with its first cost reporting period beginning after the date of its classification.

(i) It was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983.

(ii) It is classified on or before December 31, 1990, or, if on December 19, 1989, the hospital was located in a State operating a demonstration project under section 1814(b) of the Act, the classification is made on or before December 31, 1991.

(iii) It demonstrates that the entire facility is organized primarily for treatment of and research on cancer (that is, the facility is not a subunit of an acute general hospital or university-based medical center).

(iv) It shows that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease. (The principal diagnosis for this purpose is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. For the purposes of meeting this definition, only discharges with ICD-9-CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect neoplastic disease.)

(2) *Alternative.* A hospital that applied for and was denied, on or before December 31, 1990, classification as a cancer hospital under the criteria set forth in paragraph (f)(1) of this section is classified as a cancer hospital and is excluded from the prospective payment systems beginning with its first cost reporting period beginning on or after

January 1, 1991, if it meets the criterion set forth in paragraph (f)(1)(i) of this section and the hospital is—

(i) Licensed for fewer than 50 acute care beds as of August 5, 1997;

(ii) Is located in a State that as of December 19, 1989, was not operating a demonstration project under section 1814(b) of the Act; and

(iii) Demonstrates that, for the 4-year period ending on December 31, 1996, at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

(g) *Hospitals outside the 50 States, the District of Columbia, or Puerto Rico.* A hospital is excluded from the prospective payment systems if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(h) *Hospitals reimbursed under special arrangements.* A hospital must be excluded from prospective payment for inpatient hospital services if it is reimbursed under special arrangement as provided in § 412.22(c).

(i) *Changes in classification of hospitals.* For purposes of exclusions from the prospective payment system, the classification of a hospital is effective for the hospital's entire cost reporting period. Any changes in the classification of a hospital are made only at the start of a cost reporting period.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35688, Sept. 3, 1985; 51 FR 22041, June 17, 1986; 51 FR 31496, Sept. 3, 1986; 52 FR 33057, Sept. 1, 1987; 55 FR 36068, Sept. 4, 1990; 55 FR 46887, Nov. 7, 1990; 56 FR 43240, Aug. 30, 1991; 57 FR 39820, Sept. 1, 1992; 59 FR 45396, Sept. 1, 1994; 60 FR 45846, Sept. 1, 1995; 62 FR 46026, Aug. 29, 1997; 66 FR 39933, Aug. 1, 2001; 66 FR 41386, Aug. 7, 2001; 67 FR 56048, Aug. 30, 2002; 68 FR 45469, Aug. 1, 2003]

#### § 412.25 Excluded hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment systems specified in § 412.1(a)(1), a psychiatric or rehabilitation unit must meet the following requirements.

(1) Be part of an institution that—

(i) Has in effect an agreement under part 489 of this chapter to participate as a hospital;

(ii) Is not excluded in its entirety from the prospective payment systems; and

(iii) Has enough beds that are not excluded from the prospective payment systems to permit the provision of adequate cost information, as required by § 413.24(c) of this chapter.

(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.

(3) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(4) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.

(5) Meet applicable State licensure laws.

(6) Have utilization review standards applicable for the type of care offered in the unit.

(7) Have beds physically separate from (that is, not commingled with) the hospital's other beds.

(8) Be serviced by the same fiscal intermediary as the hospital.

(9) Be treated as a separate cost center for cost finding and apportionment purposes.

(10) Use an accounting system that properly allocates costs.

(11) Maintain adequate statistical data to support the basis of allocation.

(12) Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital.

(13) As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.

(b) *Changes in the size of excluded units.* For purposes of exclusions from the prospective payment systems under this section, changes in the number of beds and square footage considered to be part of each excluded unit are allowed as specified in paragraphs (b)(1) through (b)(3) of this section.

(1) *Increase in size.* Except as described in paragraph (b)(3) of this section, the number of beds and square



footage of an excluded unit may be increased only at the start of a cost reporting period.

(2) *Decrease in size.* Except as described in paragraph (b)(3) of this section, the number of beds and square footage of an excluded unit may be decreased at any time during a cost reporting period if the hospital notifies its fiscal intermediary and the CMS Regional Office in writing of the planned decrease at least 30 days before the date of the decrease, and maintains the information needed to accurately determine costs that are attributable to the excluded unit. Any decrease in the number of beds or square footage considered to be part of an excluded unit made during a cost reporting period must remain in effect for the rest of that cost reporting period.

(3) *Exception to changes in square footage and bed size.* The number of beds in an excluded unit may be decreased, and the square footage considered to be part of the unit may be either increased or decreased, at any time, if these changes are made necessary by relocation of a unit—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(c) *Changes in the status of hospital units.* For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) The status of a hospital unit may be changed from not excluded to excluded only at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next cost reporting period.

(2) The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date

of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

(d) *Number of excluded units.* Each hospital may have only one unit of each type (psychiatric or rehabilitation) excluded from the prospective payment systems.

(e) *Satellite facilities.* (1) For purposes of paragraphs (e)(2) through (e)(4) of this section, a satellite facility is a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraphs (e)(3) and (e)(5) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

(i) In the case of a unit excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the unit's number of State-licensed and Medicare-certified beds, including those at the satellite facility, does not exceed the unit's number of State-licensed and Medicare-certified beds on the last day of the unit's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For a rehabilitation unit, the requirements under § 412.23(b)(2); or

(B) For a psychiatric unit, the requirements under § 412.27(a).

(iii) The satellite facility meets all of the following requirements:

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel

who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

(B) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(C) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(D) It is serviced by the same fiscal intermediary as the hospital unit of which it is a part.

(E) It is treated as a separate cost center of the hospital unit of which it is a part.

(F) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(G) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

(3) Except as specified in paragraph (e)(4) of this section, the provisions of paragraph (e)(2) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999.

(4) In applying the provisions of paragraph (e)(3) of this section, any unit structured as a satellite facility as of September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility at any time, if these changes are made necessary by relocation of the facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(5) The provisions of paragraph (e)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.

(f) *Changes in classification of hospital units.* For purposes of exclusions from the prospective payment system under this section, the classification of a hospital unit is effective for the unit's entire cost reporting period. Any changes in the classification of a hospital unit is made only at the start of a cost reporting period.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39820, Sept. 1, 1992; 58 FR 46337, Sept. 1, 1993; 59 FR 45400, Sept. 1, 1994; 64 FR 41540, July 30, 1999; 66 FR 39933, Aug. 1, 2001; 66 FR 41387, Aug. 7, 2001; 67 FR 50111, Aug. 1, 2002; 68 FR 45469 and 45698, Aug. 1, 2003]

#### **§412.27 Excluded psychiatric units: Additional requirements.**

In order to be excluded from the prospective payment systems, a psychiatric unit must meet the following requirements:

(a) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the Third Edition of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five ("Mental Disorders") of the International Classification of Diseases, Ninth Revision, Clinical Modification.

(b) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, occupational therapy, and recreational therapy.

(c) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements:

(1) *Development of assessment/diagnostic data.* Medical records must stress the psychiatric components of the record, including history of findings

and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.

(i) The identification data must include the inpatient's legal status.

(ii) A provisional or admitting diagnosis must be made on every inpatient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(iii) The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both.

(iv) The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

(v) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

(2) *Psychiatric evaluation.* Each inpatient must receive a psychiatric evaluation that must—

(i) Be completed within 60 hours of admission;

(ii) Include a medical history;

(iii) Contain a record of mental status;

(iv) Note the onset of illness and the circumstances leading to admission;

(v) Describe attitudes and behavior;

(vi) Estimate intellectual functioning, memory functioning, and orientation; and

(vii) Include an inventory of the inpatient's assets in descriptive, not interpretative fashion.

(3) *Treatment plan.*

(i) Each inpatient must have an individual comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized; the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out; and

(ii) The treatment received by the inpatient must be documented in such a

way as to assure that all active therapeutic efforts are included.

(4) *Recording progress.* Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the inpatient but must be recorded at least weekly for the first two months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the inpatient's progress in accordance with the original or revised treatment plan.

(5) *Discharge planning and discharge summary.* The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.

(d) Meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning, as follows:

(1) *Personnel.* The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to—

(i) Evaluate inpatients;

(ii) Formulate written, individualized, comprehensive treatment plans;

(iii) Provide active treatment measures; and

(iv) Engage in discharge planning.

(2) *Director of inpatient psychiatric services: Medical staff.* Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.

(i) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(ii) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

(3) *Nursing services.* The unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each inpatient's active treatment program and to maintain progress notes on each inpatient.

(i) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

(ii) The staffing pattern must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each inpatient's active treatment program.

(4) *Psychological services.* The unit must provide or have available psychological services to meet the needs of the inpatients. The services must be furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures.

(5) *Social services.* There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and

procedures. Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.

(6) *Therapeutic activities.* The unit must provide a therapeutic activities program.

(i) The program must be appropriate to the needs and interests of inpatients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

(ii) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each inpatient's active treatment program.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39820, Sept. 1, 1992; 59 FR 45397, 45400, Sept. 1, 1994]

#### **§ 412.29 Excluded rehabilitation units: Additional requirements.**

In order to be excluded from the prospective payment systems described in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2), a rehabilitation unit must meet the following requirements:

(a) Have met either the requirements for—

(1) New units under § 412.30(a); or

(2) Converted units under § 412.30(c).

(b) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient program or assessment.

(c) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social services or psychological services, and orthotic and prosthetic services.

(d) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.

(e) Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment.

(f) Have a director of rehabilitation who—

(1) Provides services to the unit and to its inpatients for at least 20 hours per week;

(2) Is a doctor of medicine or osteopathy;

(3) Is licensed under State law to practice medicine or surgery; and

(4) Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39821, Sept. 1, 1992; 59 FR 45397, 45400, Sept. 1, 1994; 60 FR 45847, Sept. 1, 1995; 66 FR 41387, Aug. 7, 2001; 68 FR 45699, Aug. 1, 2003]

**§ 412.30 Exclusion of new rehabilitation units and expansion of units already excluded.**

(a) *Bed capacity in units.* A decrease in bed capacity must remain in effect for at least a full 12-month cost reporting period before an equal or lesser number of beds can be added to the hospital's licensure and certification and considered "new" under paragraph (b) of this section. Thus, when a hospital seeks to establish a new unit under the criteria under paragraph (b) of this section, or to enlarge an existing unit under the criteria under paragraph (d) of this section, the regional office will review its records on the facility to determine whether any beds have been delicensed and decertified during the 12-month cost reporting period before the period for which the hospital seeks to add the beds. To the extent bed capacity was removed from the hospital's licensure and certification during that period, that amount of bed capacity may not be considered "new" under paragraph (b) of this section.

(b) *New units.* (1) A hospital unit is considered a new unit if the hospital—

(i) Has not previously sought exclusion for any rehabilitation unit; and

(ii) Has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds in the unit.

(2) A hospital that seeks exclusion of a new rehabilitation unit may provide a written certification that the inpatient population the hospital intends the unit to serve meets the requirements of § 412.23(b)(2) instead of showing that the unit has treated such a population during the hospital's most recent cost reporting period.

(3) The written certification described in paragraph (b)(2) of this section is effective for the first full cost reporting period during which the unit is used to provide hospital inpatient care.

(4) If a hospital that has not previously participated in the Medicare program seeks exclusion of a rehabilitation unit, it may designate certain beds as a new rehabilitation unit for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital. The written certification described in paragraph (b)(2) of this section also is effective for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(5) A hospital that has undergone a change of ownership or leasing as defined in § 489.18 of this chapter is not considered to have participated previously in the Medicare program.

(c) *Converted units.* A hospital unit is considered a converted unit if it does not qualify as a new unit under paragraph (a) of this section. A converted unit must have treated, for the hospital's most recent 12-month cost reporting period, an inpatient population of which at least 75 percent required intensive rehabilitation services for the treatment of one or more conditions listed under § 412.23(b)(2).

(d) *Expansion of excluded rehabilitation units.*—(1) *New bed capacity.* The beds

that a hospital seeks to add to its excluded rehabilitation unit are considered new beds only if—

(i) The hospital's State-licensed and Medicare-certified bed capacity increases at the start of the cost reporting period for which the hospital seeks to increase the size of its excluded rehabilitation unit, or at any time after the start of the preceding cost reporting period; and

(ii) The hospital has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds it seeks to add to the unit.

(2) *Conversion of existing bed capacity.*

(i) Bed capacity is considered to be existing bed capacity if it does not meet the definition of new bed capacity under paragraph (d)(1) of this section.

(ii) A hospital may increase the size of its excluded rehabilitation unit through conversion of existing bed capacity only if it shows that, for all of the hospital's most recent cost reporting period of at least 12 months, the beds have been used to treat an inpatient population meeting the requirements of § 412.23(b)(2).

(e) *Retroactive adjustments for certain units.* For cost reporting periods beginning on or after October 1, 1991, if a hospital has a new rehabilitation unit excluded from the prospective payment systems for a cost reporting period under paragraph (a) of this section or expands an existing rehabilitation unit under paragraph (c) of this section, but the inpatient population actually treated in the new unit or the beds added to the existing unit during that cost reporting period does not meet the requirements in § 412.23(b)(2), CMS adjusts payments to the hospital retroactively in accordance with the provisions in § 412.130 of this part.

[50 FR 12741, Mar. 29, 1985, as amended at 56 FR 43420, Aug. 30, 1991; 57 FR 39821, Sept. 1, 1992; 59 FR 45400, Sept. 1, 1994; 60 FR 45847, Sept. 1, 1995; 62 FR 46027, Aug. 29, 1997; 68 FR 45699, Aug. 1, 2003]

### **Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs**

#### **§ 412.40 General requirements.**

(a) A hospital must meet the conditions of this subpart to receive payment under the prospective payment systems for inpatient hospital services furnished to Medicare beneficiaries.

(b) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may, as appropriate—

(1) Withhold Medicare payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

(2) Terminate the hospital's provider agreement.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39821, Sept. 1, 1992]

#### **§ 412.42 Limitations on charges to beneficiaries.**

(a) *Prohibited charges.* A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment systems.

(b) *Permitted charges—Stay covered.* A hospital receiving payment under the prospective payment systems for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the following:

(1) The applicable deductible and co-insurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter.

(2) Noncovered items and services, furnished at any time during a covered stay, unless they are excluded from coverage only on the basis of the following:

(i) The exclusion of custodial care under § 405.310(g) of this chapter (see paragraph (c) of this section for when

charges may be made for custodial care).

(ii) The exclusion of medically unnecessary items and services under § 405.310(k) of this chapter (see paragraphs (c) and (d) of this section for when charges may be made for medically unnecessary items and services).

(iii) The exclusion under § 405.310(m) of this chapter of nonphysician services furnished to hospital inpatients by other than the hospital or a provider or supplier under arrangements made by the hospital.

(iv) The exclusion of items and services furnished when the patient is not entitled to Medicare Part A benefits under subpart A of part 406 of this chapter (see paragraph (e) of this section for when charges may be made for items and services furnished when the patient is not entitled to benefits).

(v) The exclusion of items and services furnished after Medicare Part A benefits are exhausted under § 409.61 of this chapter (see paragraph (e) of this section for when charges may be made for items and services furnished after benefits are exhausted).

(c) *Custodial care and medically unnecessary inpatient hospital care.* A hospital may charge a beneficiary for services excluded from coverage on the basis of § 411.15(g) of this chapter (custodial care) or § 411.15(k) of this chapter (medically unnecessary services) and furnished by the hospital after all of the following conditions have been met:

(1) The hospital (acting directly or through its utilization review committee) determines that the beneficiary no longer requires inpatient hospital care. (The phrase “inpatient hospital care” includes cases where a beneficiary needs a SNF level of care, but, under Medicare criteria, a SNF-level bed is not available. This also means that a hospital may find that a patient awaiting SNF placement no longer requires inpatient hospital care because either a SNF-level bed has become available or the patient no longer requires SNF-level care.)

(2) The attending physician agrees with the hospital’s determination in writing (for example, by issuing a written discharge order). If the hospital believes that the beneficiary does not re-

quire inpatient hospital care but is unable to obtain the agreement of the physician, it may request an immediate review of the case by the QIO. Concurrence by the QIO in the hospital’s determination will serve in lieu of the physician’s agreement.

(3) The hospital (acting directly or through its utilization review committee) notifies the beneficiary (or person acting on his or her behalf) in writing that—

(i) In the hospital’s opinion, and with the attending physician’s concurrence or that of the QIO, the beneficiary no longer requires inpatient hospital care;

(ii) Customary charges will be made for continued hospital care beyond the second day following the date of the notice;

(iii) The QIO will make a formal determination on the validity of the hospital’s finding if the beneficiary remains in the hospital after he or she is liable for charges;

(iv) The determination of the QIO made after the beneficiary received the purportedly noncovered services will be appealable by the hospital, the attending physician, or the beneficiary under the appeals procedures that apply to QIO determinations affecting Medicare Part A payment; and

(v) The charges for continued care will be invalid and refunded if collected by the hospital, to the extent that a finding is made that the beneficiary required continued care beyond the point indicated by the hospital.

(4) If the beneficiary remains in the hospital after the appropriate notification, and the hospital, the physician who concurred in the hospital determination on which the notice was based, or QIO subsequently finds that the beneficiary requires an acute level of inpatient hospital care, the hospital may not charge the beneficiary for continued care until the hospital once again determines that the beneficiary no longer requires inpatient care, secures concurrence, and notifies the beneficiary, as required in paragraphs (c)(1), (c)(2), and (c)(3) of this section.

(d) *Medically unnecessary diagnostic and therapeutic services.* A hospital may charge a beneficiary for diagnostic procedures and studies, and therapeutic procedures and courses of treatment

(for example, experimental procedures) that are excluded from coverage under § 405.310(k) of this chapter (medically unnecessary items and services), even though the beneficiary requires continued inpatient hospital care, if those services are furnished after the beneficiary (or the person acting on his or her behalf) has acknowledged in writing that the hospital (acting directly or through its utilization review committee and with the concurrence of the intermediary) has informed him or her as follows:

(1) In the hospital's opinion, which has been agreed to by the intermediary, the services to be furnished are not considered reasonable and necessary under Medicare.

(2) Customary charges will be made if he or she receives the services.

(3) If the beneficiary receives the services, a formal determination on the validity of the hospital's finding is made by the intermediary and, to the extent that the decision requires the exercise of medical judgment, the QIO.

(4) The determination is appealable by the hospital, the attending physician, or the beneficiary under the appeals procedure that applies to determinations affecting Medicare Part A payment.

(5) The charges for the services will be invalid and, to the extent collected, will be refunded by the hospital if the services are found to be covered by Medicare.

(e) *Services furnished on days when the individual is not entitled to Medicare Part A benefits or has exhausted the available benefits.* The hospital may charge the beneficiary its customary charges for noncovered items and services furnished on outlier days (as described in Subpart F of this part) for which payment is denied because the beneficiary is not entitled to Medicare Part A or his or her Medicare Part A benefits are exhausted. (1) If payment is considered for outlier days, the entire stay is reviewed and days up to the number of days in excess of the outlier threshold may be denied on the basis of non-entitlement to Part A or exhaustion of benefits. (2) In applying this rule, the latest days will be denied first.

(f) *Differential for private room or other luxury services.* The hospital may

charge the beneficiary the customary charge differential for a private room or other luxury service that is more expensive than is medically required and is furnished for the personal comfort of the beneficiary at his or her request (or the request of the person acting on his or her behalf).

(g) *Review.* (1) The QIO or intermediary may review any cases in which the hospital advises the beneficiary (or the person acting on his or her behalf) of the noncoverage of the services in accordance with paragraph (c)(3) or (d) of this section.

(2) The hospital must identify such cases to the QIO or intermediary in accordance with CMS instructions.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35688, Sept. 3, 1985; 54 FR 41747, Oct. 11, 1989; 57 FR 39821, Sept. 1, 1992]

#### **§ 412.44 Medical review requirements: Admissions and quality review.**

Beginning on November 15, 1984, a hospital must have an agreement with a QIO to have the QIO review, on an ongoing basis, the following:

(a) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges.

(b) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§ 412.82 and 412.84 of this chapter.

(c) The validity of the hospital's diagnostic and procedural information.

(d) The completeness, adequacy, and quality of the services furnished in the hospital.

(e) Other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

[50 FR 15326, Apr. 17, 1985, as amended at 50 FR 35689, Sept. 3, 1985; 50 FR 41886, Oct. 16, 1985]

#### **§ 412.46 Medical review requirements: Physician acknowledgement.**

(a) *Basis.* Because payment under the prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's



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medical record, physicians must complete an acknowledgement statement to this effect.

(b) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(c) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

[60 FR 45847, Sept. 1, 1995]

### § 412.48 Denial of payment as a result of admissions and quality review.

(a) If CMS determines, on the basis of information supplied by a QIO that a hospital has misrepresented admissions, discharges, or billing information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, CMS may as appropriate—

(1) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided with respect to such an unnecessary admission or subsequent readmission of an individual; or

(2) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(b) When payment with respect to admission of an individual patient is denied by a QIO under paragraph (a)(1) of this section, and liability is not waived in accordance with §§ 405.330 through 405.332 of this chapter, notice and appeals are provided under procedures established by CMS to implement the provisions of section 1155 of the Act, Right to Hearing and Judicial Review.

(c) A determination under paragraph (a) of this section, if it is related to a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment systems, is referred to the Department's Office of Inspector General, for handling in accordance with § 1001.301 of this title.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35688, 35689, Sept. 3, 1985; 51 FR 34787, Sept. 30, 1986; 57 FR 39821, Sept. 1, 1992]

### § 412.50 Furnishing of inpatient hospital services directly or under arrangements.

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following types of services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this chapter.

(b) CMS does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for the services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The hospital must furnish all necessary covered services to the beneficiary either directly or under arrangements (as defined in § 409.3 of this chapter).

[50 FR 12741, Mar. 29, 1985, as amended at 53 FR 38527, Sept. 30, 1988; 57 FR 39821, Sept. 1, 1992; 60 FR 63188, Dec. 8, 1995; 65 FR 18537, Apr. 7, 2000]

**§ 412.52 Reporting and recordkeeping requirements.**

All hospitals participating in the prospective payment systems must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 57 FR 39821, Sept. 1, 1992]

**Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs**

**§ 412.60 DRG classification and weighting factors.**

(a) *Diagnosis-related groups.* CMS establishes a classification of inpatient hospital discharges by Diagnosis-Related Groups (DRGs).

(b) *DRG weighting factors.* CMS assigns, for each DRG, an appropriate weighting factor that reflects the estimated relative cost of hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(c) *Assignment of discharges to DRGs.* CMS establishes a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge.

(1) The classification of a particular discharge is based, as appropriate, on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

(2) Each discharge is assigned to only one DRG (related, except as provided in

paragraph (c)(3) of this section, to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill is returned to the hospital for validation and reverification. CMS's DRG classification system provides a DRG, and an appropriate weighting factor, for the group of cases for which the unrelated diagnosis and procedure are confirmed.

(d) *Review of DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews the hospital's request and any additional information and decides whether a change in the DRG assignment is appropriate. If the intermediary decides that a higher-weighted DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in § 466.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (d)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

(e) *Revision of DRG classification and weighting factors.* Beginning with discharges in fiscal year 1988, CMS adjusts the classifications and weighting factors established under paragraphs (a) and (b) of this section at least annually to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources.

[50 FR 12741, Mar. 29, 1985, as amended at 52 FR 33057, Sept. 1, 1987; 57 FR 39821, Sept. 1, 1992; 59 FR 45397, Sept. 1, 1994]

**§ 412.62 Federal rates for inpatient operating costs for fiscal year 1984.**

(a) *General rule.* CMS determines national adjusted DRG prospective payment rates for operating costs, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a hospital in the United

States subject to the prospective payment system under subpart B of this part, and determines regional adjusted DRG prospective payment rates for inpatient operating costs for such discharges in each region, for which payment may be made under Medicare Part A. Such rates are determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described in paragraphs (b) through (k) of this section.

(b) *Determining allowable individual hospital inpatient operating costs.* CMS determines the Medicare allowable operating costs per discharge of inpatient hospital services for each hospital in the data base for the most recent cost reporting period for which data are available.

(c) *Updating for fiscal year 1984.* CMS updates each amount determined under paragraph (b) of this section for fiscal year 1984 by—

(1) Updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under paragraph (b) of this section and fiscal year 1983; and

(2) Projecting for fiscal year 1984 by the applicable percentage increase in the hospital market basket for fiscal year 1984.

(d) *Standardizing amounts.* CMS standardizes the amount updated under paragraph (c) of this section for each hospital by—

(1) Adjusting for area variations in case mix among hospitals;

(2) Excluding an estimate of indirect medical education costs;

(3) Adjusting for area variations in hospital wage levels; and

(4) Adjusting for the effects of a higher cost of living for hospitals located in Alaska and Hawaii.

(e) *Computing urban and rural averages.* CMS computes an average of the standardized amounts determined under paragraph (d) of this section for urban and rural hospitals in the United States and for urban and rural hospitals in each region.

(f) *Geographic classifications.* (1) For purposes of paragraph (e) of this section, the following definitions apply:

(i) The term *region* means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21, 42 U.S.C. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(iii) The term *rural area* means any area outside an urban area.

(iv) The phrase *hospital reclassified as rural* means a hospital located in a county that was part of an MSA or NECMA, as defined by the Executive Office of Management and Budget, but is not part of an MSA or NECMA as a result of an Executive Office of Management and Budget redesignation occurring after April 20, 1983.

(2) For hospitals within an MSA or NECMA that crosses census division boundaries, the following provisions apply:

(i) The MSA or NECMA is deemed to belong to the census division in which most of the hospitals within the MSA or NECMA are located.

(ii) If a hospital would receive a lower Federal rate because most of the hospitals are located in a census division with a lower Federal rate than the rate applicable to the census division in which the hospital is located, the payment rate will not be reduced for the hospital's cost reporting period beginning before October 1, 1984.

(iii) If an equal number of hospitals within the MSA or NECMA are located in each census division, such hospitals are deemed to be in the census division with the higher Federal rate.

(g) *Adjusting the average standardized amounts.* CMS adjusts each of the average standardized amounts determined under paragraphs (c), (d), and (e) of this

section by factors representing CMS's estimates of the following:

(1) The amount of payment that would have been made under Medicare Part B for nonphysician services to hospital inpatients during the first cost reporting period subject to prospective payment were it not for the fact that such services must be furnished either directly by hospitals or under arrangements in order for any Medicare payment to be made after September 30, 1983 (the effective date of § 405.310(m) of this chapter).

(2) The amount of FICA taxes that would be incurred during the first cost reporting period subject to the prospective payment system, by hospitals that had not incurred such taxes for any or all of their employees during the base period described in paragraph (c) of this section.

(h) *Reducing for value of outlier payments.* CMS reduces each of the adjusted average standardized amounts determined under paragraphs (c) through (g) of this section by a proportion equal to the proportion (estimated by CMS) of the total amount of payments based on DRG prospective payment rates that are additional payments for outlier cases under subpart F of this part.

(i) *Maintaining budget neutrality.* (1) CMS adjusts each of the reduced standardized amounts determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) is not greater or less than 25 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the Social Security Act as in effect on April 19, 1983.

(2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.

(j) *Computing Federal rates for inpatient operating costs for urban and rural hospitals in the United States and in each region.* For each discharge classified within a DRG, CMS establishes a national prospective payment rate for inpatient operating costs and a regional prospective payment rate for inpatient operating costs for each region, as follows:

(1) For hospitals located in an urban area in the United States or in that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraphs (c) through (i) of this section) for hospitals located in an urban area in the United States or in that region; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in a rural area in the United States or in that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraphs (c) through (i) of this section) for hospitals located in a rural area in the United States or that region; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(k) *Adjusting for different area wage levels.* CMS adjusts the proportion (as estimated by CMS from time to time) of Federal rates computed under paragraph (j) of this section that are attributable to wages and labor-related costs, for area differences in hospital wage levels by a factor (established by CMS) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (f) of this section) of the hospital compared to the national average hospital wage level.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 53 FR 38527, Sept. 30, 1988; 57 FR 39821, Sept. 1, 1992; 58 FR 46337, Sept. 1, 1993]

**§ 412.63 Federal rates for inpatient operating costs for fiscal years after Federal fiscal year 1984.**

(a) *General rule.* (1) CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a

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Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) Each such rate is determined for hospitals located in urban or rural areas within the United States and within each such region respectively, as described in paragraphs (b) through (g) of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, except that, effective January 1, 2000, a hospital reclassified as rural may mean a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.

(2) For hospitals within an MSA or NECMA that crosses census division boundaries, the following provisions apply:

(i) The MSA or NECMA is deemed to belong to the census division in which most of the hospitals within the MSA or NECMA are located.

(ii) A hospital that met the conditions specified in § 412.62(f)(2)(ii) and therefore did not receive a lower Federal rate that would have applied for cost reporting periods beginning before October 1, 1984, receives the lower Federal rate applicable to all hospitals in the MSA or NECMA in which it is located effective with the hospital's cost reporting period that begins on or after October 1, 1984.

(iii) The higher Federal rate is payable to all hospitals in the MSA or NECMA if an equal number of hospitals within the MSA or NECMA are located in each census division.

(3) For discharges occurring on or after October 1, 1988, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be con-

sidered part of an urban area, under the standards for designating MSAs or NECMAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs or NECMAs. These EOMB standards are set forth in the notice of final standards for classification of MSAs published in the FEDERAL REGISTER on January 3, 1980 (45 FR 956), and available from CMS, East High Rise Building, room 132, 6325 Security Boulevard, Baltimore, Maryland 21207.

(4) For purposes of this section, any change in an MSA or NECMA designation is recognized on the October 1 following the effective date of the change.

(5) For discharges occurring on or after October 1, 1988, for hospitals that consist of two or more separately located inpatient hospital facilities the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurs.

(c) *Updating previous standardized amounts.* (1) CMS computes an average standardized amount for hospitals in urban areas and rural areas within the United States, and urban areas and rural areas within each region.

(2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under § 412.62(g)—

(i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;

(ii) Adjusted by the estimated amount of Medicare payment for non-physician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and

(iv) Adjusted for budget neutrality under paragraph (h) of this section.

(3) For fiscal year 1986 and thereafter, CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective adjusted average standardized amounts computed for the previous fiscal year—

(i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;

(ii) Adjusted by the estimated amount of Medicare payment for non-physician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and

(iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by CMS) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by CMS) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

(4) For fiscal years 1987 through 1990 CMS standardizes the average standardized amounts by excluding an estimate of the payments for hospitals that serve a disproportionate share of low-income patients.

(5) For fiscal year 1987 onward, CMS restandardizes the average standardized amounts by excluding an estimate of indirect medical education payments.

(6) For fiscal year 1988 and thereafter, CMS computes average standardized amounts for hospitals located in large urban areas, other urban areas, and rural areas. The term *large urban area* means an MSA with a population of more than 1,000,000 or an NECMA, with a population of more than 970,000 based on the most recent available popu-

lation data published by the Bureau of the Census.

(d) *Applicable percentage change for fiscal year 1986.* (1) The applicable percentage change for fiscal year 1986 is—

(i) For discharges occurring on or after October 1, 1985 and before May 1, 1986, zero percent; and

(ii) For discharges occurring on or after May 1, 1986, one-half of one percent.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1986, the applicable percentage increase for fiscal year 1986 is deemed to have been one-half of one percent.

(e) *Applicable percentage change for fiscal year 1987.* The applicable percentage change for fiscal year 1987 is 1.15 percent.

(f) *Applicable percentage change for fiscal year 1988.* (1) The applicable percentage change for fiscal year 1988 is—

(i) For discharges occurring on or after October 1, 1987 and before November 21, 1987, zero percent;

(ii) For discharges occurring on or after November 21, 1987 and before April 1, 1988, 2.7 percent; and

(iii) For discharges occurring on or after April 1, 1988 and before October 1, 1988—

(A) 3.0 percent for hospitals located in rural areas;

(B) 1.5 percent for hospitals located in large urban areas; and

(C) 1.0 percent for hospitals located in other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1988 (for Federal fiscal year 1989), the applicable percentage change for fiscal year 1988 is deemed to have been—

(i) 3.0 percent for hospitals located in rural areas;

(ii) 1.5 percent for hospitals located in large urban areas; and

(iii) 1.0 percent for hospitals located in other urban areas.

(g) *Applicable percentage change for fiscal year 1989.* The applicable percentage change for fiscal year 1989 is the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter)—

(1) Minus 1.5 percentage points for hospitals located in rural areas;

(2) Minus 2.0 percentage points for hospitals in large urban areas; and

(3) Minus 2.5 percentage points for hospitals in other urban areas.

(h) *Applicable percentage change for fiscal year 1990.* (1) The applicable percentage change for fiscal year 1990 is—

(i) For discharges occurring on or after October 1, 1989 and before January 1, 1990, 5.5 percent; and

(ii) For discharges occurring on or after January 1, 1990 and before October 1, 1990—

(A) 9.72 percent for hospitals located in rural areas;

(B) 5.62 percent for hospitals located in large urban areas; and

(C) 4.97 percent for hospitals located in other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1990, the applicable percentage change for fiscal year 1990 is deemed to have been the percentage change provided for in paragraph (h)(1)(ii) of this section.

(i) *Applicable percentage change for fiscal year 1991.* (1) The applicable percentage change for fiscal year 1991 is—

(i) For discharges occurring on or after October 1, 1990 and before October 21, 1990, 5.2 percent;

(ii) For discharges occurring on or after October 21, 1990 and before January 1, 1991, 0.0 percent; and

(iii) For discharges occurring on or after January 1, 1991 and before October 1, 1991—

(A) 4.5 percent for hospitals located in rural areas; and

(B) 3.2 percent for hospitals located in large urban areas and other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1991, the applicable percentage change for fiscal year 1991 is deemed to have been the percentage change provided for in paragraph (i)(1)(iii) of this section.

(j) *Applicable percentage change for fiscal year 1992.* The applicable percentage change for fiscal year 1992 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a)(3) of this chapter)—

(1) Minus 0.6 percentage points for hospitals located in rural areas.

(2) Minus 1.6 percentage points for hospitals located in large urban areas and other urban areas.

(k) *Applicable percentage change for fiscal year 1993.* The applicable percentage change for fiscal year 1993 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a)(3) of this chapter)—

(1) Minus 0.55 percentage points for hospitals located in rural areas.

(2) Minus 1.55 percentage points for hospitals located in large urban areas and other urban areas.

(l) *Applicable percentage change for fiscal year 1994.* The applicable percentage change for fiscal year 1994 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter)—

(1) Minus 1.0 percentage point for hospitals located in rural areas.

(2) Minus 2.5 percentage points for hospitals located in large urban areas and other urban areas.

(m) *Applicable percentage change for fiscal year 1995.* The applicable percentage change for fiscal year 1995 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter)—

(1) Plus, for hospitals located in rural areas, the percentage increase necessary so that the average standardized amounts computed under paragraph (c) through (i) of this section are equal to the average standardized amounts for hospitals located in an urban area other than a large urban area.

(2) Minus 2.5 percentage points for hospitals located in large urban areas and other urban areas.

(n) *Applicable percentage change for fiscal year 1996.* The applicable percentage change for fiscal year 1996 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 2.0 percentage points for all areas.

(o) *Applicable percentage change for fiscal year 1997.* The applicable percentage change for fiscal year 1997 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this

chapter) minus 0.5 percentage point for all areas.

(p) *Applicable percentage change for fiscal year 1998.* The applicable percentage change for fiscal year 1998 is 0 percent for hospitals in all areas.

(q) *Applicable percentage change for fiscal year 1999.* The applicable percentage change for fiscal year 1999 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 1.9 percentage points for hospitals in all areas.

(r) *Applicable percentage change for fiscal year 2000.* The applicable percentage change for fiscal year 2000 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 1.8 percentage points for hospitals in all areas.

(s) *Applicable percentage change for fiscal year 2001.* The applicable percentage change for discharges occurring in fiscal year 2001 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas as follows:

(1) For discharges occurring on October 1, 2000 or before April 1, 2001 the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for sole community hospitals and the increase in the market basket index minus 1.1 percentage points for other hospitals in all areas; and

(2) For discharges occurring on April 1, 2001 or before October 1, 2001 the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for sole community hospitals and the increase in the market basket index plus 1.1 percentage points for other hospitals in all areas.

(t) *Applicable percentage change for fiscal years 2002 and 2003.* The applicable percentage change for fiscal years 2002 and 2003 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 0.55 percentage points for hospitals in all areas.

(u) *Applicable percentage change for fiscal year 2004 and for subsequent fiscal years.* The applicable percentage change for fiscal year 2004 and for subsequent years is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

(v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is not greater or less than 50 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the law as in effect on April 19, 1983.

(2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.

(w) *Computing Federal rates for inpatient operating costs for hospitals located in large urban and other areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a national prospective payment rate and a regional prospective payment rate for inpatient operating costs, for each region, as follows:

(1) For hospitals located in a large urban area in the United States or that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a large urban area in the United States or in that region; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in an other area in the United States or that region respectively, the rate equals the product of—



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(i) The adjusted average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in an other area in the United States or that region; and

(ii) The weighting factor (determined under § 412.60(b)) for that DRG.

(x) *Adjusting for different area wage levels.* (1) CMS adjusts the proportion (as estimated by CMS from time to time) of Federal rates for inpatient operating costs computed under paragraph (j) of this section that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The wage index is updated annually.

(2)(i) CMS makes a midyear correction to the wage index for an area only if a hospital can show that—

(A) The intermediary or CMS made an error in tabulating its data; and

(B) The hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.

(ii) A midyear correction to the wage index is effective prospectively from the date the change is made to the wage index.

(3) If a judicial decision reverses a CMS denial of a hospital's wage data revision request, CMS pays the hospital by applying a revised wage index that reflects the revised wage data as if CMS's decision had been favorable rather than unfavorable.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.63, see the List of Sections Affected, which appears in the finding Aids section of the printed volume and on GPO Access.

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### Subpart E—Determination of Transition Period Payment Rates for the Prospective Payment System for Inpatient Operating Costs

#### 412.70 General description.

For discharges occurring on or after April 1, 1988, and before October 1, 1996, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

[57 FR 39822, Sept. 1, 1992, as amended at 58 FR 46338, Sept. 1, 1993]

#### § 412.71 Determination of base-year inpatient operating costs.

(a) *Base-year costs.* (1) For each hospital, the intermediary will estimate the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(2) If the hospital's last cost reporting period ending before September 30, 1983 is for less than 12 months, the base period will be the hospital's most recent 12-month or longer cost reporting period ending before such short reporting period, with an appropriate adjustment for inflation. (The rules applicable to new hospitals are set forth in § 412.74.)

(b) *Modifications to base-year costs.* Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs in accordance with § 413.53(a)(1)(i) of this chapter, and exclude the following:

(1) Medical education costs as described in § 413.85 of this chapter.

(2) Capital-related costs as described in § 413.130 of this chapter.

(3) Kidney acquisition costs incurred by hospitals approved as renal transplantation centers as described in § 412.100. Kidney acquisition costs in

the base year will be determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period.

(4) Higher costs that were incurred for purposes of increasing base-year costs.

(5) One-time nonrecurring higher costs or revenue offsets that have the effect of distorting base-year costs as an appropriate basis for computing the hospital-specific rate.

(6) Higher costs that result from changes in hospital accounting principles initiated in the base year.

(7) The costs of qualified nonphysician anesthesiologists' services, as described in § 412.113(c).

(c) *Hospital's request for adjustment of base-year inpatient operating costs.* (1) Before the date it becomes subject to the prospective payment system for inpatient operating costs, a hospital may request the intermediary to further adjust its estimated base-period costs to take into account the following:

(i) Services paid for under Medicare Part B during the hospital's base year that will be paid for under prospective payments. The base-year costs may be increased to include estimated payments for certain services previously billed as physicians' services before the effective date of § 415.102(a) of this chapter, and estimated payments for nonphysicians' services that were not furnished either directly or under arrangements before October 1, 1983 (the effective date of § 405.310(m) of this chapter), but may not include the costs of anesthesiologists' services for which a physician employer continues to bill under § 405.553(b)(4) of this chapter.

(ii) The payment of FICA taxes during cost reporting periods subject to the prospective payment system, if the hospital had not paid such taxes for all its employees during its base period and will be required to participate effective January 1, 1984.

(2) If a hospital requests that its base-period costs be adjusted under paragraph (c)(1) of this section, it must timely provide the intermediary with sufficient documentation to justify the adjustment, and adequate data to compute the adjusted costs. The inter-

mediary decides whether to use part or all of the data on the basis of audit, survey and other information available.

(d) *Intermediary's determination.* The intermediary uses the best data available at the time in estimating each hospital's base-year costs and the modifications to those costs authorized by paragraphs (b) and (c) of this section. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 52 FR 33057, Sept. 1, 1987; 57 FR 33897, July 31, 1992; 57 FR 39822, Sept. 1, 1992; 59 FR 45398, Sept. 1, 1994; 60 FR 63188, Dec. 8, 1995]

#### § 412.72 Modification of base-year costs.

(a) *Bases for modification of base-year costs.* Base-year costs as determined under § 412.71(d) may be modified under the following circumstances:

(1) *Inadvertent omissions.* (i) A hospital that becomes subject to the prospective payment system beginning on or after October 1, 1983 and before November 16, 1983 has until November 15, 1983 to request its intermediary to re-estimate its base-period costs to take into account inadvertent omissions in its previous submissions to the intermediary related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(ii) The intermediary may also initiate changes to the estimation—

(A) For any reason before the date the hospital becomes subject to prospective payment; and

(B) Before November 16, 1983, for corrections to take into account inadvertent omissions in the hospital's previous submissions related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(iii) Such omissions pertain to adjustments to exclude capital-related costs and the direct medical education

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costs of approved educational activities and to adjustments specified in § 412.71(c).

(iv) The intermediary must notify the provider of any change to the hospital-specific amount as a result of the provider's request within 30 days of receipt of the additional data.

(v) Any change to base-period costs made under this paragraph (a)(1) will be made effective retroactively, beginning with the first day of the affected hospital's fiscal year.

(2) *Correction of mathematical errors of calculations.* (i) The hospital must report mathematical errors of calculations to the intermediary within 90 days of the intermediary's notification to the hospital of the hospital's payments rates.

(ii) The intermediary may also identify such errors and initiate their correction during this period.

(iii) The intermediary will either make an appropriate adjustment or notify the hospital that no adjustment is warranted within 30 days of receipt of the hospital's report of an error.

(iv) Corrections of errors of calculation will be effective with the first day of the hospital's first cost reporting period subject to the prospective payment system.

(3) *Recognition of additional costs.* (i) The intermediary may adjust base-period costs to take into account additional costs recognized as allowable costs for the hospital's base year as the result of any of the following:

(A) A reopening and revision of the hospital's base-year notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(B) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(C) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(D) An administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(ii) The intermediary will recalculate the hospital's base-year costs, incorporating the additional costs recognized as allowable for the hospital's base year. Adjustments to base-year costs to take into account these additional costs—

(A) Will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the revision, order or finding, or review decision; and

(B) Will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the revision, order or finding, or review decision.

(4) *Successful appeal.* The intermediary may modify base-year costs to take into account a successful appeal relating to modifications to base-year costs that were made under § 412.71(b). If a hospital successfully contests a modification to base-year costs—

(i) The intermediary will recalculate the hospital's base-year costs to reflect the modification determined appropriate as a result of the appeal; and

(ii) Such adjustments will be effective retroactively to the time of the intermediary's initial estimation of base-year costs.

(5) *Unlawfully claimed costs.* The intermediary may modify base-year costs to exclude costs that were unlawfully claimed as determined as a result of criminal conviction, imposition of a civil judgment under the False Claims Act (31 U.S.C. 3729–3731), or a proceeding for exclusion from the Medicare program. In addition to adjusting base-year costs, CMS will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. The amount to be recovered will be

computed on the basis of the final resolution of the amount of the inappropriate base-year costs.

(b) *Right to administrative and judicial review.* (1) An intermediary's estimation of a hospital's base-year costs, and modifications, made for purposes of determining the hospital-specific rate, are subject to administrative and judicial review. Review will be available to a hospital upon receipt of its notice of amount of program reimbursement following the close of its cost reporting period, but only with respect to whether the intermediary followed the provisions of §§412.71 and 412.72. (Sections 405.1803 and 405.1807 of this chapter set forth the rules for intermediary determinations and notice of amount of program reimbursement and the effect of those determinations.)

(2) In any administrative or judicial review of whether the intermediary used the best data available at the time, as required by §412.71(d), an intermediary's estimation will be revised on the basis of this review only if the estimation was unreasonable and clearly erroneous in light of the data available at the time the estimation was made.

(3) Specifically excluded from administrative or judicial review are any issues based on data, information, or arguments not presented to the intermediary at the time of the estimation.

**§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.**

(a) *Costs on a per discharge basis.* The intermediary will determine the hospital's estimated adjusted base-year operating cost per discharge by dividing the total adjusted operating costs by the number of discharges in the base period.

(b) *Case-mix adjustment.* The intermediary will divide the adjusted base-year costs by the hospital's 1981 case-mix index. If the hospital's case-mix index is statistically unreliable (as determined by CMS), the hospital's base-year costs will be divided by the lower of the following:

(1) The hospital's estimated case-mix index.

(2) The average case-mix index for the appropriate classifications of all hospitals subject to cost limits established under §413.30 of this chapter for cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983.

(c) *Updating base-year costs—*(1) *For Federal fiscal year 1984.* The case-mix adjusted base-year cost per discharge will be updated by the applicable updating factor, that is, the rate-of-increase percentage determined under §413.40(c)(3) of this chapter, as adjusted for budget neutrality.

(2) *For Federal fiscal year 1985.* The amount determined under paragraph (c)(1) of this section will be updated by the applicable updating factor, as adjusted for budget neutrality.

(3) *For Federal fiscal year 1986.* (i) The amount determined under paragraph (c)(2) of this section is updated by—

(A) Zero percent for the first seven months of the hospital's cost reporting period; and

(B) One-half of one percent for the remaining five months of the hospital's cost reporting period.

(ii) For purposes of determining the updated base-year costs for cost reporting periods beginning in Federal fiscal year 1987 (that is, on or after October 1, 1986 and before October 1, 1987), the update factor for the previous cost reporting period is deemed to have been one-half of one percent.

(4) *For Federal fiscal year 1987.* The amount determined under paragraph (c)(3)(ii) of this section is updated by 1.15 percent.

(5) *For Federal fiscal year 1988.* (i) For purposes of determining the prospective payment rates for sole community hospitals under §412.92(d) for cost reporting periods beginning in Federal fiscal year 1988 (that is, on or after October 1, 1987 and before October 1, 1988), the base-year cost per discharge is updated as follows:

(A) For the first 51 days of the hospital's cost reporting period, by zero percent.

(B) For the next 132 days of the hospital's cost reporting period, by 2.7 percent.

(C) For the remainder of the hospital's cost reporting period, by—

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(1) 3.0 percent for hospitals located in rural areas;

(2) 1.5 percent for hospitals located in large urban areas; and

(3) 1.0 percent for hospitals located in other urban areas.

(ii) For purposes of determining the updated base-year costs for cost reporting periods beginning in Federal fiscal year 1989 (that is, beginning on or after October 1, 1988 and before October 1, 1989), the update factor for the cost reporting period beginning during federal Fiscal year 1988 is deemed to have been—

(A) 3.0 percent for hospitals located in rural areas;

(B) 1.5 percent for hospitals located in large urban areas; and

(C) 1.0 percent for hospitals located in other urban areas.

(6) *For Federal fiscal year 1989.* For cost reporting periods beginning in Federal fiscal year 1989, the update factor is determined using the methodology set forth in § 412.63(g).

(7) *For Federal fiscal year 1990.* (i) Except as described in paragraph (c)(7)(ii) of this section, for cost reporting periods beginning in Federal fiscal year 1990, the base-period cost per discharge is updated as follows:

(A) For cost reporting periods beginning on or after October 1, 1989 and before January 1, 1990, by 5.5 percent for discharges occurring before January 1, 1990 and by the factors set forth in paragraph (c)(7)(i)(B) of this section for discharges occurring on or after January 1, 1990.

(B) For cost reporting periods beginning on or after January 1, 1990 and before October 1, 1990, by—

(1) 9.72 percent for hospitals located in rural areas;

(2) 5.62 percent for hospitals located in large urban areas; and

(3) 4.97 percent for hospitals located in other urban areas.

(ii) For discharges occurring on or after October 21, 1990 and before January 1, 1991, the base-period cost per discharge, updated as set forth in paragraph (c)(7)(i) of this section, is reduced by 5.5 percent.

(iii) For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1991 (that is, beginning on

or after October 1, 1990 and before October 1, 1991), the update factor for the cost reporting period beginning during Federal fiscal year 1990 is deemed to have been the percentage change provided for in paragraph (c)(7)(i)(B) of this section.

(8) *For Federal fiscal year 1991.* (i) Except as described in paragraph (c)(8)(ii) of this section, for cost reporting periods beginning in Federal fiscal year 1991, the base-period cost per discharge is updated by 5.2 percent.

(ii) For discharges occurring on or after October 21, 1990 and before January 1, 1991, the base-period cost per discharge is updated by 0.0 percent.

(iii) For purposes of determining the updated base period costs for cost reporting periods beginning in Federal fiscal year 1992, the update factor for the cost reporting period beginning during Federal fiscal year 1991 is deemed to have been the percentage change provided for in paragraph (c)(8)(i) of this section.

(9) *For Federal fiscal years 1992 and 1993.* For Federal fiscal years 1992 and 1993, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter).

(10) *For Federal fiscal year 1994.* For Federal fiscal year 1994, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of the chapter) minus 2.3 percentage points. For purposes of determining the hospital-specific rate for Federal fiscal year 1994 and subsequent years, this update factor is adjusted to take into account the portion of the 12-month cost reporting period beginning during Federal fiscal year 1993 that occurs in Federal fiscal year 1994.

(11) *For Federal fiscal year 1995.* For Federal fiscal year 1995, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 2.2 percentage points.

(12) *For Federal fiscal years 1996 through 2000.* For Federal fiscal years 1996 through 2000, the update factor is the applicable percentage change for other prospective payment hospitals in

each respective year as set forth in §§ 412.63(n) through (r).

(13) *For Federal fiscal year 2001.* For Federal fiscal year 2001, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter).

(14) *For Federal fiscal year 2002.* For Federal fiscal year 2002, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 1.1 percentage points.

(15) *For Federal fiscal year 2003 and for subsequent years.* For Federal fiscal year 2003 and subsequent years, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter).

(d) *Budget neutrality—(1) Federal fiscal year 1984.* For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, CMS adjusts the target rate percentage used under paragraph (c)(1) of this section. This adjustment is based on a factor actuarially estimated to ensure that the estimated amount of aggregate Medicare payments based on the hospital-specific portion of the transition payment rates is neither greater nor less than 75 percent of the amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the law in effect before April 20, 1983.

(2) *Federal fiscal year 1985.* For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1985, CMS adjusts the target rate percentage used under paragraph (c)(2) of this section. This adjustment is based on a factor actuarially estimated to ensure that the estimated amount of aggregate Medicare payment based on the hospital-specific portion of the transition payment rates is neither greater nor less than 50 percent of the amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the Social Security Act as in effect on April 19, 1983.

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG

weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 16787, May 6, 1986; 51 FR 34793, Sept. 30, 1986; 51 FR 42234, Nov. 24, 1986; 52 FR 33057, Sept. 1, 1987; 53 FR 38528, Sept. 30, 1988; 55 FR 15173, Apr. 20, 1990; 56 FR 573, Jan. 7, 1991; 57 FR 39822, Sept. 1, 1992; 58 FR 46338, Sept. 1, 1993; 59 FR 1658, Jan. 12, 1994; 59 FR 32383, June 23, 1994; 65 FR 47106, Aug. 1, 2000]

**§ 412.75 Determination of the hospital-specific rate for inpatient operating costs based on a Federal fiscal year 1987 base period.**

(a) *Base-period costs—(1) General rule.* Except as provided in paragraph (a)(2) of this section, for each hospital, the intermediary determines the hospital's Medicare part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1987 and before September 30, 1988.

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 1988 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 1987 and before September 30, 1988 and does have a cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. In that case, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period.

(b) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

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(c) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(d) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1988, the update factor is determined using the methodology set forth in §412.73 (c)(15).

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(f) *Notice of hospital-specific rate.* The intermediary furnishes the hospital a notice of its hospital-specific rate, which contains a statement of the hospital's Medicare part A allowable inpatient operating costs, number of Medicare discharges, and case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 1987 base period.

(g) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to a hospital upon receipt of the notice of the hospital-specific rate. This notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

(h) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the hospital's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement de-

termination, the actions taken on administrative or judicial review that provide a basis for recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under §405.1821 or §405.1853 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under §405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under §§405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (h) (1) and (2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

[55 FR 15173, Apr. 20, 1990, as amended at 55 FR 36069, Sept. 4, 1990; 55 FR 39775, Sept. 2, 1990; 56 FR 573, Jan. 7, 1991; 55 FR 46887, Nov. 7, 1990; 57 FR 39822, Sept. 1, 1992; 58 FR 46338, Sept. 1, 1993; 65 FR 47106, Aug. 1, 2000]

### **§412.77 Determination of the hospital-specific rate for inpatient operating costs for sole community hospitals based on a Federal fiscal year 1996 base period.**

(a) *Applicability.* (1) This section applies to a hospital that has been designated as a sole community hospital, as described in §412.92. If the 1996 hospital-specific rate exceeds the rate that would otherwise apply, that is, either the Federal rate under §412.63 or the

hospital-specific rates for either fiscal year 1982 under § 412.73 or fiscal year 1987 under § 412.75, this 1996 rate will be used in the payment formula set forth in § 412.92(d)(1).

(2) This section applies only to cost reporting periods beginning on or after October 1, 2000.

(3) The formula for determining the hospital-specific costs for hospitals described under paragraph (a)(1) of this section is set forth in paragraph (f) of this section.

(b) *Based costs for hospitals subject to fiscal year 1996 rebasing.* (1) *General rule.* Except as provided in paragraph (b)(2) of this section, for each hospital eligible under paragraph (a) of this section, the intermediary determines the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and computes the hospital-specific rate for purposes of determining prospective payment rates for inpatient operating costs as determined under § 412.92(d).

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 1997 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and does have a cost reporting period beginning on or after October 1, 1995 and before October 1, 1996, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. If that cost reporting period is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period. If a hospital has no cost reporting period beginning in fiscal year 1996, the hospital will not have a hospital-specific rate based on fiscal year 1996.

(c) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of dis-

charges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(d) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(e) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1996, the update factor is determined using the methodology set forth in § 412.73(c)(12) through (c)(15).

(f) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(g) *Notice of hospital-specific rates.* The intermediary furnishes a hospital eligible for rebasing a notice of the hospital-specific rate as computed in accordance with this section. The notice will contain a statement of the hospital's Medicare Part A allowable inpatient operating costs, the number of Medicare discharges, and the case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 1996 base period.

(h) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to a hospital upon receipt of the notice of the hospital-specific rate. This notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter.

(i) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the hospital's base period as a result of administrative or judicial review of the base-



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period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for the recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (i)(1) and (i)(2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

[65 FR 47106, Aug. 1, 2000, as amended at 66 FR 32192, June 13, 2001]

### **§ 412.78 Recovery of excess transition period payment amounts resulting from unlawful claims.**

If a hospital's base-year costs, as estimated for purposes of determining the hospital-specific portion, are determined, by criminal conviction or imposition of a civil money penalty or assessment, to include costs that were

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unlawfully claimed, the hospital's base-period costs are adjusted to remove the effect of the excess costs, and CMS recovers both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39822, Sept. 1, 1992. Redesignated at 65 FR 47106, Aug. 1, 2000]

### **Subpart F—Payment for Outlier Cases and Special Treatment Payment for New Technology**

#### **PAYMENT FOR OUTLIER CASES**

#### **412.80 Outlier cases: General provisions.**

(a) *Basic rule*—(1) *Discharges occurring on or after October 1, 1994 and before October 1, 1997.* For discharges occurring on or after October 1, 1994, and before October 1, 1997, except as provided in paragraph (b) of this section concerning transferring hospitals, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if either of the following conditions is met:

(i) The beneficiary's length-of-stay (including days at the SNF level of care if a SNF bed is not available in the area) exceeds the mean length-of-stay for the applicable DRG by the lesser of the following:

(A) A fixed number of days, as specified by CMS; or

(B) A fixed number of standard deviations, as specified by CMS.

(ii) The beneficiary's length-of-stay does not exceed criteria established under paragraph (a)(1)(i) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

(2) *Discharges occurring on or after October 1, 1997 and before October 1, 2001.* For discharges occurring on or after

October 1, 1997 and before October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios, as described in § 412.84(h), exceed the DRG payment for the case, payments for indirect costs of graduate medical education (§ 412.105), and payments for serving disproportionate share of low-income patients (§ 412.106), plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

(3) *Discharges occurring on or after October 1, 2001.* For discharges occurring on or after October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments and beyond additional payments for new medical services or technology specified in §§ 412.87 and 412.88, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case (plus payments for indirect costs of graduate medical education (§ 412.105), payments for serving a disproportionate share of low-income patients (§ 412.106), and additional payments for new medical services or technologies) plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

(b) *Outlier cases in transferring hospitals.* CMS provides cost outlier payments to a transferring hospital for cases paid in accordance with § 412.4(f), if the hospital's charges for covered services furnished to the beneficiary, adjusted to costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS, divided by the geometric mean length of stay for the DRG, and multiplied by an applicable factor determined as follows:

(1) For transfer cases paid in accordance with § 412.4(f)(1), the applicable factor is equal to the length of stay plus 1 day.

(2) For transfer cases paid in accordance with § 412.4(f)(2), the applicable factor is equal to 0.5 plus the product of the length of stay plus 1 day multiplied by 0.5.

(c) *Publication and revision of outlier criteria.* CMS will issue threshold criteria for determining outlier payment in the annual notice of the prospective payment rates published in accordance with § 412.8(b).

[62 FR 46028, Aug. 29, 1997, as amended at 63 FR 41003, July 31, 1998; 66 FR 46924, Sept. 7, 2001; 67 FR 50111, Aug. 1, 2002]

#### **§ 412.82 Payment for extended length-of-stay cases (day outliers).**

(a) For discharges occurring before October 1, 1997, if the hospital stay reflected by a discharge includes covered days of care beyond the applicable threshold criterion, the intermediary will make an additional payment, on a per diem basis, to the discharging hospital for those days. A special request or submission by the hospital is not necessary to initiate this payment. However, a hospital may request payment for day outliers before the medical review required in paragraph (b) of this section.

(b) The QIO must review and approve to the extent required by CMS—

(1) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay;

(2) The validity of the diagnostic and procedural coding; and

(3) The granting of grace days.

(c) Except as provided in § 412.86, the per diem payment made under paragraph (a) of this section is derived by taking a percentage of the average per diem payment for the applicable DRG, as calculated by dividing the Federal prospective payment rate for inpatient operating costs and inpatient capital-related costs determined under subpart D of this part, by the arithmetic mean length of stay for that DRG. CMS issues the applicable percentage of the average per diem payment in the annual publication of the prospective

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payment rates in accordance with § 412.8(b).

(d) Any days in a covered stay identified as noncovered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 15326, Apr. 17, 1985; 50 FR 35689, Sept. 3, 1985; 53 FR 38529, Sept. 30, 1988; 57 FR 39822, Sept. 1, 1992; 59 FR 45398, Sept. 1, 1994; 62 FR 46028, Aug. 29, 1997]

### § 412.84 Payment for extraordinarily high-cost cases (cost outliers).

(a) A hospital may request its intermediary to make an additional payment for inpatient hospital services that meet the criteria established in accordance with § 412.80(a).

(b) The hospital must request additional payment—

(1) With initial submission of the bill; or

(2) Within 60 days of receipt of the intermediary's initial determination.

(c) Except as specified in paragraph (e) of this section, an additional payment for a cost outlier case is made prior to medical review.

(d) As described in paragraph (f) of this section, the QIO reviews a sample of cost outlier cases after payment. The charges for any services identified as noncovered through this review are denied and any outlier payment made for these services are recovered, as appropriate, after a determination as to the provider's liability has been made.

(e) If the QIO finds a pattern of inappropriate utilization by a hospital, all cost outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the QIO determines that appropriate corrective actions have been taken.

(f) The QIO reviews the cost outlier cases, using the medical records and itemized charges, to verify the following:

(1) The admission was medically necessary and appropriate.

(2) Services were medically necessary and delivered in the most appropriate setting.

(3) Services were ordered by the physician, actually furnished, and not duplicatively billed.

(4) The diagnostic and procedural codings are correct.

(g) The intermediary bases the operating and capital costs of the discharge on the billed charges for covered inpatient services adjusted by the cost to charge ratios applicable to operating and capital costs, respectively, as described in paragraph (h) of this section.

(h) For discharges occurring before October 1, 2003, the operating and capital cost-to-charge ratios used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. For discharges occurring before August 8, 2003, statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. CMS sets forth the reasonable parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published in the FEDERAL REGISTER in accordance with § 412.8(b).

(i)(1) For discharges occurring on or after August 8, 2003, CMS may specify an alternative to the ratios otherwise applicable under paragraphs (h) or (i)(2) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS Regional Office.

(2) For discharges occurring on or after October 1, 2003, the operating and capital cost-to-charge ratios applied at the time a claim is processed are based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.

(3) For discharges occurring on or after August 8, 2003, the fiscal intermediary may use a statewide average cost-to-charge ratio if it is unable to determine an accurate operating or capital cost-to-charge ratio for a hospital in one of the following circumstances:

(i) New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(ii) Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.8(b).

(iii) Other hospitals for whom the fiscal intermediary obtains accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.

(4) For discharges occurring on or after August 8, 2003, any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(j) If any of the services are determined to be noncovered, the charges for these services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

(k) Except as provided in paragraph (l) of this section, the additional amount is derived by first taking 80 percent of the difference between the hospital's adjusted operating cost for the discharge (as determined under paragraph (g) of this section) and the operating threshold criteria established under § 412.80(a)(1)(ii); 80 percent is also taken of the difference between the hospital's adjusted capital cost for the discharge (as determined under paragraph (g) of this section) and the capital threshold criteria established under § 412.80(a)(1)(ii). The resulting capital amount is then multiplied by the applicable Federal portion of the payment as determined in § 412.340(a) or § 412.344(a).

(l) For discharges occurring on or after April 1, 1988, the additional payment amount for the DRGs related to

burn cases, which are identified in the most recent annual notice of prospective payment rates published in accordance with § 412.8(b), is computed under the provisions of paragraph (k) of this section except that the payment is made using 90 percent of the difference between the hospital's adjusted cost for the discharge and the threshold criteria.

(m) Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under paragraph (h)(3) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35689, Sept. 3, 1985; 51 FR 31496, Sept. 3, 1986; 53 FR 38529, Sept. 30, 1988; 54 FR 36494, Sept. 1, 1989; 55 FR 15174, Apr. 20, 1990; 56 FR 43448, Aug. 30, 1991; 57 FR 39823, Sept. 1, 1992; 59 FR 45398, Sept. 1, 1994; 62 FR 46028, Aug. 29, 1997; 68 FR 34515, June 9, 2003]

#### **§ 412.86 Payment for extraordinarily high-cost day outliers.**

For discharges occurring before October 1, 1997, if a discharge that qualifies for an additional payment under the provisions of § 412.82 has charges adjusted to costs that exceed the cost outlier threshold criteria for an extraordinarily high-cost case as set forth in § 412.80(a)(1)(ii), the additional payment made for the discharge is the greater of—

(a) The applicable per diem payment computed under § 412.82 (c) or (d); or

(b) The payment that would be made under § 412.84 (i) or (j) if the case had not met the day outlier criteria threshold set forth in § 412.80(a)(1)(i).

[53 FR 38529, Sept. 30, 1988, as amended at 62 FR 46028, Aug. 29, 1997]

#### **ADDITIONAL SPECIAL PAYMENT FOR CERTAIN NEW TECHNOLOGY**

#### **§ 412.87 Additional payment for new medical services and technologies: General provisions.**

(a) *Basis.* Sections 412.87 and 412.88 implement sections 1886(d)(5)(K) and

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1886(d)(5)(L) of the Act, which authorize the Secretary to establish a mechanism to recognize the costs of new medical services and technologies under the hospital inpatient prospective payment system.

(b) *Eligibility criteria.* For discharges occurring on or after October 1, 2001, CMS provides for additional payments (as specified in § 412.88) beyond the standard DRG payments and outlier payments to a hospital for discharges involving covered inpatient hospital services that are new medical services and technologies, if the following conditions are met:

(1) A new medical service or technology represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries. CMS will determine whether a new medical service or technology meets this requirement and announce the results of its determinations in the FEDERAL REGISTER as a part of its annual updates and changes to the hospital inpatient prospective payment system.

(2) A medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new service or technology (depending on when a new code is assigned and data on the new service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered “new” under the criterion of this section.

(3) The DRG prospective payment rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate, based on application of a threshold amount to estimated charges incurred with respect to such discharges. To determine whether the payment would be adequate, CMS will determine whether the charges of the cases involving a new medical service or technology will exceed a threshold amount set at 75 percent of one standard deviation beyond the geometric mean standardized

charge for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs if the new medical service or technology occurs in many different DRGs). Standardized charges reflect the actual charges of a case adjusted by the prospective payment system payment factors applicable to an individual hospital, such as the wage index, the indirect medical education adjustment factor, and the disproportionate share adjustment factor.

[66 FR 46924, Sept. 7, 2001, as amended at 68 FR 45469, Aug. 1, 2003]

### **§ 412.88 Additional payment for new medical service or technology.**

(a) For discharges involving new medical services or technologies that meet the criteria specified in § 412.87, Medicare payment will be:

(1) One of the following:

(i) The full DRG payment (including adjustments for indirect medical education and disproportionate share but excluding outlier payments);

(ii) The payment determined under § 412.4(f) for transfer cases;

(iii) The payment determined under § 412.92(d) for sole community hospitals; or

(iv) The payment determined under § 412.108(c) for Medicare-dependent hospitals; plus

(2) If the costs of the discharge (determined by applying cost-to-charge ratios as described in § 412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of—

(i) 50 percent of the costs of the new medical service or technology; or

(ii) 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

(b) Unless a discharge case qualifies for outlier payment under § 412.84, Medicare will not pay any additional amount beyond the DRG payment plus 50 percent of the estimated costs of the new medical service or technology.

(c) If CMS estimates before the beginning of a Federal fiscal year that the additional payments under this section would exceed 1.0 percent of total operating payments under the hospital inpatient prospective payment system, the additional payment

amounts under paragraph (a) of this section will be reduced prospectively to a percentage estimated to result in payments not to exceed 1.0 percent of total operating payments under the hospital inpatient prospective payment system.

[66 FR 46924, Sept. 7, 2001, as amended at 67 FR 50111, Aug. 1, 2002]

### Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

#### § 412.90 General rules.

(a) *Sole community hospitals.* CMS may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under § 412.92(a), its prospective payment rates for inpatient operating costs are determined under § 412.92(d).

(b) *Referral center.* CMS may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth in § 412.96.

(c) [Reserved]

(d) *Kidney acquisition costs incurred by hospitals approved as renal transplantation centers.* CMS pays for kidney acquisition costs incurred by renal transplantation centers on a reasonable cost basis. The criteria for this special payment provision are set forth in § 412.100.

(e) *Hospitals located in areas that are reclassified from urban to rural.* (1) CMS adjusts the rural Federal payment amounts for inpatient operating costs for hospitals located in geographic areas that are reclassified from urban to rural as defined in § 412.62(f). This adjustment is set forth in § 412.102.

(2) CMS establishes a procedure by which certain individual hospitals lo-

cated in urban areas may apply for reclassification as rural. The criteria for reclassification are set forth in § 412.103.

(f) *Hospitals that have a high percentage of ESRD beneficiary discharges.* CMS makes an additional payment to a hospital if ten percent or more of its total Medicare discharges in a cost reporting period beginning on or after October 1, 1984 are ESRD beneficiary discharges. In determining ESRD discharges, discharges in DRG Nos. 302, 316, and 317 are excluded. The criteria for this additional payment are set forth in § 412.104.

(g) *Hospitals that incur indirect costs for graduate medical education programs.* CMS makes an additional payment for inpatient operating costs to a hospital for indirect medical education costs attributable to an approved graduate medical education program. The criteria for this additional payment are set forth in § 412.105.

(h) *Hospitals that serve a disproportionate share of low-income patients.* For discharges occurring on or after May 1, 1986, CMS makes an additional payment for inpatient operating costs to hospitals that serve a disproportionate share of low-income patients. The criteria for this additional payment are set forth in § 412.106.

(i) *Hospitals that receive an additional update for FYs 1998 and 1999.* For FYs 1998 and 1999, CMS makes an upward adjustment to the standardized amounts for certain hospitals that do not receive indirect medical education or disproportionate share payments and are not Medicare-dependent, small rural hospitals. The criteria for identifying these hospitals are set forth in § 412.107.

(j) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990 and before October 1, 1994, or beginning on or after October 1, 1997 and before October 1, 2006, CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital.

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(k) *Essential access community hospitals (EACHs)*. If a hospital was designated as an EACH by CMS as described in § 412.109(a) and is located in a rural area as defined in § 412.109(b), CMS determines the prospective payment rate for that hospital, as it does for sole community hospitals, under § 412.92(d).

[57 FR 39823, Sept. 1, 1992, as amended at 58 FR 30669, May 26, 1993; 62 FR 46028, Aug. 29, 1997; 64 FR 67051, Nov. 30, 1999; 65 FR 47047, Aug. 1, 2000]

### § 412.92 Special treatment: Sole community hospitals.

(a) *Criteria for classification as a sole community hospital*. CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in § 412.83(b)) and meets one of the following conditions:

(1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:

(i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;

(ii) The hospital has fewer than 50 beds and the intermediary certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or

(iii) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

(b) *Classification procedures*. (1) *Request for classification as sole community hospital*. (i) The hospital must make its request to its fiscal intermediary.

(ii) If a hospital is seeking sole community hospital classification under paragraph (a)(1)(i) or (a)(1)(ii) of this section, the hospital must include the following information with its request:

(A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area.

(B) The hospital must provide patient origin data from all other hospitals located within a 35 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care.

(iii)(A) If the hospital is unable to obtain the information required under paragraph (b)(1)(ii)(A) of this section concerning the residences of Medicare beneficiaries who were inpatients in other hospitals located within a 35 mile radius of the hospital or, if larger, within the hospital's service area, the hospital may request that CMS provide this information.

(B) If a hospital obtains the information as requested under paragraph (b)(1)(iii)(A) of this section, that information is used by both the intermediary and CMS in making the determination of the residences of Medicare beneficiaries under paragraphs (b)(1)(iii) and (b)(1)(iv) of this section, regardless of any other information concerning the residences of Medicare beneficiaries submitted by the hospital.

(iv) The intermediary reviews the request and send the request, with its recommendation, to CMS.

(v) CMS reviews the request and the intermediary's recommendation and

forward its approval or disapproval to the intermediary.

(2) *Effective dates of classification.* (i) Sole community hospital status is effective 30 days after the date of CMS's written notification of approval.

(ii) When a court order or a determination by the Provider Reimbursement Review Board (PRRB) reverses an CMS denial of sole community hospital status and no further appeal is made, the sole community hospital status is effective as follows:

(A) If the hospital's application was submitted prior to October 1, 1983, its status as a sole community hospital is effective at the start of the cost reporting period for which it sought exemption from the cost limits.

(B) If the hospital's application for sole community hospital status was filed on or after October 1, 1983, the effective date is 30 days after the date of CMS's original written notification of denial.

(iii) When a hospital is granted retroactive approval of sole community hospital status by a court order or a PRRB decision and the hospital wishes its sole community hospital status terminated before the date of the court order or PRRB determination, it must submit written notice to the CMS regional office within 90 days of the court order or PRRB decision. A written request received after the 90-day period is effective no later than 30 days after the request is submitted.

(iv) A hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of CMS's approval of the classification.

(3) *Duration of classification.* An approved classification as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(4) *Cancellation of classification.* (i) A hospital may at any time request cancellation of its classification as a sole community hospital, and be paid at rates determined under subparts D and E of this part, as appropriate.

(ii) The cancellation becomes effective no later than 30 days after the date the hospital submits its request.

(iii) If a hospital requests that its sole community hospital classification be cancelled, it may not be reclassified as a sole community hospital unless it meets the following conditions:

(A) At least one full year has passed since the effective date of its cancellation.

(B) The hospital meets the qualifying criteria set forth in paragraph (a) of this section in effect at the time it re-applies.

(5) *Automatic classification as a sole community hospital.* A hospital that has been granted an exemption from the hospital cost limits before October 1, 1983, or whose request for the exemption was received by the appropriate intermediary before October 1, 1983, and was subsequently approved, is automatically classified as a sole community hospital unless that classification has been cancelled under paragraph (b)(3) of this section, or there is a change in the circumstances under which the classification was approved.

(c) *Terminology.* As used in this section—

(1) The term *miles* means the shortest distance in miles measured over improved roads. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the hospital.

(2) The term *like hospital* means a hospital furnishing short-term, acute care. Effective with cost reporting periods beginning on or after October 1, 2002, for purposes of a hospital seeking sole community hospital designation, CMS will not consider the nearby hospital to be a like hospital if the total inpatient days attributable to units of the nearby hospital that provides a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system are less than or equal to 8 percent of the similarly calculated total inpatient days of the hospital seeking sole community hospital designation.

(3) The term *service area* means the area from which a hospital draws at



least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as a sole community hospital.

(d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals.* (1) *General rule.* For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:

(i) The Federal payment rate applicable to the hospitals as determined under § 412.63.

(ii) The hospital-specific rate as determined under § 412.73.

(iii) The hospital-specific rate as determined under § 412.75.

(iv) For cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate as determined under § 412.77 (calculated under the transition schedule set forth in paragraph (d)(2) of this section).

(2) *Transition of FY 1996 hospital-specific rate.* The intermediary calculates the hospital-specific rate determined on the basis of the fiscal year 1996 base period rate as follows:

(i) For Federal fiscal year 2001, the hospital-specific rate is the sum of 75 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 25 percent of the hospital-specific rate as determined under § 412.77.

(ii) For Federal fiscal year 2002, the hospital-specific rate is the sum of 50 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 50 percent of the hospital-specific rate as determined under § 412.77.

(iii) For Federal fiscal year 2003, the hospital-specific rate is the sum of 25 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 75 percent of the hospital-specific rate as determined under § 412.77.

(iv) For Federal fiscal year 2004 and any subsequent fiscal years, the hospital-specific rate is 100 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

(3) *Adjustments to payments.* A sole community hospital may receive an adjustment to its payments to take into account a significant decrease in number of discharges or a significant increase in inpatient operating costs, as described in paragraphs (e) and (g) of this section respectively.

(e) *Additional payments to sole community hospitals experiencing a significant volume decrease.* (1) For cost reporting periods beginning on or after October 1, 1983, the intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.

(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement—

(i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to circumstances beyond the hospital's control.

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a

disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105).

(i) In determining the adjustment amount, the intermediary considers—

(A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization.

(ii) The intermediary makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.

(iii) The intermediary determination is subject to review under subpart R of part 405 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 31496, Sept. 3, 1986; 51 FR 34793, Sept. 30, 1986; 52 FR 30367, Aug. 14, 1987; 52 FR 33057, Sept. 1, 1987; 53 FR 38529, Sept. 30, 1988; 54 FR 36494, Sept. 1, 1989; 55 FR 14283, Apr. 17, 1990; 55 FR 15174, Apr. 20, 1990; 55 FR 36070, Sept. 4, 1990; 56 FR 25487, June 4, 1991; 57 FR 39823, Sept. 1, 1992; 60 FR 45848, Sept. 1, 1995; 65 FR 47107, Aug. 1, 2000; 66 FR 32193, June 13, 2001; 66 FR 39933, Aug. 1, 2001; 67 FR 50111, Aug. 1, 2002]

#### § 412.96 Special treatment: Referral centers.

(a) *Criteria for classification as a referral center: Basic rule.* CMS classifies a hospital as a referral center only if the hospital is a Medicare participating acute care hospital and meets the applicable criteria of paragraph (b) or (c) of this section.

(b) *Criteria for cost reporting periods beginning on or after October 1, 1983.* The hospital meets either of the following criteria:

(1) The hospital is located in a rural area (as defined in § 412.63(b)) and has the following number of beds, as determined under the provisions of § 412.105(b), available for use:

(i) Effective for discharges occurring before April 1, 1988, the hospital has 500 or more beds.

(ii) Effective for discharges occurring on or after April 1, 1988, the hospital has 275 or more beds during its most recently completed cost reporting period unless the hospital submits written documentation with its application that its bed count has changed since the close of its most recently completed cost reporting period for one or more of the following reasons:

(A) Merger of two or more hospitals.

(B) Reopening of acute care beds previously closed for renovation.

(C) Transfer to the prospective payment system of acute care beds previously classified as part of an excluded unit.

(D) Expansion of acute care beds available for use and permanently maintained for lodging inpatients, excluding beds in corridors and other temporary beds.

(2) The hospital shows that—(i) At least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital; and

(ii) At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries are furnished to beneficiaries who live more than 25 miles from the hospital.

(c) *Alternative criteria.* For cost reporting periods beginning on or after October 1, 1985, a hospital that does not meet the criteria of paragraph (b) of this section is classified as a referral center if it is located in a rural area (as defined in § 412.62(f)) and meets the criteria specified in paragraphs (c)(1) and (c)(2) of this section and at least one of the three criteria specified in paragraphs (c)(3), (c)(4), and (c)(5) of this section.

(1) *Case-mix index.* CMS sets forth national and regional case-mix index values in each year's annual notice of prospective payment rates published under § 412.8(b). The methodology CMS uses to calculate these criteria is described in paragraph (g) of this section. The case-mix index value to be used for an individual hospital in the determination of whether it meets the case-mix index criteria is that calculated by CMS from the hospital's own billing

records for Medicare discharges as processed by the fiscal intermediary and submitted to CMS. The hospital's case-mix index for discharges (not including discharges from units excluded from the prospective payment system under subpart B of this part) during the most recent Federal fiscal year that ended at least one year prior to the beginning of the cost reporting period for which the hospital is seeking referral center status must be at least equal to—

(i) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the national or regional case-mix index value; or

(ii) For hospitals applying for rural referral center status for cost-reporting periods beginning on or after October 1, 1986, the national case-mix index value as established by CMS or the median case-mix index value for urban hospitals located in each region. In calculating the median case-mix index for each region, CMS excludes the case-mix indexes of hospitals receiving indirect medical education payments as provided in §412.105.

(2) *Number of discharges.* (i) CMS sets forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates published under §412.8(b). The methodology CMS uses to calculate these criteria is described in paragraph (h) of this section. Except as provided in paragraph (c)(2)(ii) of this section for an osteopathic hospital, for the hospital's most recently completed cost reporting period, its number of discharges (not including discharges from units excluded from the prospective payment system under subpart B of this part or from newborn units) is at least equal to—

(A) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the number of discharges under either the national or regional criterion; or

(B) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1986, 5,000 discharges or, if less, the median number of discharges for urban hospitals located in each region.

(ii) For cost reporting periods beginning on or after January 1, 1986, an osteopathic hospital, recognized by the American Osteopathic Healthcare Association (or any successor organization), that is located in a rural area must have at least 3,000 discharges during its most recently completed cost reporting period to meet the number of discharges criterion. The 3,000 discharges benchmark is also used in evaluating an osteopathic hospital for purposes of the triennial review.

(3) *Medical staff.* More than 50 percent of the hospital's active medical staff are specialists who meet one of the following conditions:

(i) Are certified as specialists by one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.

(ii) Have completed the current training requirements for admission to the certification examination of one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.

(iii) Have successfully completed a residency program in a medical specialty accredited by the Accreditation Council of Graduate Medical Education or the American Osteopathic Association.

(4) *Source of inpatients.* At least 60 percent of all its discharges are for inpatients who reside more than 25 miles from the hospital.

(5) *Volume of referrals.* At least 40 percent of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital's staff.

(d) *Payment to rural referral centers.* Effective for discharges occurring on or after April 1, 1988, and before October 1, 1994, a hospital that is located in a rural area and meets the criteria of paragraphs (b)(1), (b)(2) or (c) of this section is paid prospective payments for inpatient operating costs per discharge based on the applicable other urban payment rates as determined in accordance with §412.63, as adjusted by the hospital's area wage index.

(e)–(f) [Reserved]

(g) *Hospital cancellation of referral center status.* (1) A hospital may at any

time request cancellation of its status as a referral center and be paid prospective payments per discharge based on the applicable rural rate as determined in accordance with § 412.63, as adjusted by the hospital's area wage index value.

(2) The cancellation becomes effective no later than 30 days after the date the hospital submits its request.

(3) If a hospital requests that its referral center status be canceled, it may not be reclassified as a referral center unless it meets the qualifying criteria set forth in paragraph (a) of this section in effect at the time it reapplies.

(h) *Methodology for calculating case-mix index criteria.* CMS calculates the national and regional case-mix index value criteria as described in paragraphs (g)(1) through (g)(4) of this section.

(1) *Updating process.* CMS updates the national and regional case-mix index standards using the latest available data from hospitals subject to the prospective payment system for the Federal fiscal year.

(2) *Source of data.* In making the calculations described in paragraph (g)(1) of this section, CMS uses all inpatient hospital bills received for discharges subject to prospective payment during the Federal fiscal year being monitored.

(3) *Effective date.* CMS sets forth the national and regional criteria in the annual notice of prospective payment rates published under § 412.8(b). These criteria are used to determine if a hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

(4) *Applicability of criteria to CMS review of referral center status.* For purposes of the triennial CMS review of a referral center's status as described in paragraph (f) of this section, the referral center's case-mix index value for a Federal fiscal year is evaluated using the appropriate case-mix value criteria published in the annual notice of prospective payment rates.

(i) *Methodology for calculating number of discharges criteria.* For purposes of determining compliance with the national or regional number of discharges criterion under paragraph (c)(2) of this

section, CMS calculates the criteria as follows:

(1) *Updating process.* CMS updates the national and regional number of discharges using the latest available data for levels of admissions or discharges or both.

(2) *Source of data.* In making the calculations described in paragraph (h)(1) of this section, CMS uses the most recent hospital admissions or discharge data available.

(3) *Annual notice.* CMS sets forth the national and regional criteria in the annual notice of prospective payment rates published under § 412.8(b). These criteria are compared to an applying hospital's number of discharges for its most recently completed cost reporting period in determining if the hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

(4) *Applicability of criteria to CMS review of referral center status.* For purposes of the triennial review of a referral center's status as described in paragraph (f) of this section, the referral center's number of discharges for its most recently completed cost reporting period is evaluated using the appropriate discharge criteria published in the annual notice of prospective payment rates.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.96, see the List of Sections Affected, which appears in the Finding Aids section of the printed volume and on GPO Access.

#### § 412.98 [Reserved]

#### § 412.100 Special treatment: Renal transplantation centers.

(a) *Adjustments for renal transplantation centers.* (1) CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part for hospitals approved as renal transplantation centers (described at §§ 405.2170 and 405.2171 of this chapter) to remove the estimated net expenses associated with kidney acquisition.

(2) Kidney acquisition costs are treated apart from the prospective payment rate for inpatient operating

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costs, and payment to the hospital is adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition.

(b) *Costs of kidney acquisition.* Expenses recognized under this section include costs of acquiring a kidney, from a live donor or a cadaver, irrespective of whether the kidney was obtained by the hospital or through an organ procurement agency. These costs include—

(1) Tissue typing, including tissue typing furnished by independent laboratories;

(2) Donor and recipient evaluation;

(3) Other costs associated with excising kidneys, such as donor general routine and special care services;

(4) Operating room and other inpatient ancillary services applicable to the donor;

(5) Preservation and perfusion costs;

(6) Charges for registration of recipient with a kidney transplant registry;

(7) Surgeons' fees for excising cadaver kidneys;

(8) Transportation;

(9) Costs of kidneys acquired from other providers or kidney procurement organizations;

(10) Hospital costs normally classified as outpatient costs applicable to kidney excisions (services include donor and donee tissue typing, work-up, and related services furnished prior to admission);

(11) Costs of services applicable to kidney excisions which are rendered by residents and interns not in approved teaching programs; and

(12) All pre-admission physicians services, such as laboratory, electroencephalography, and surgeon fees for cadaver excisions, applicable to kidney excisions including the costs of physicians services.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]

### **§ 412.102 Special treatment: Hospitals located in areas that are reclassified from urban to rural as a result of a geographic redesignation.**

Effective on or after October 1, 1983, a hospital reclassified as rural, as defined in § 412.62(f), may receive an adjustment to its rural Federal payment

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amount for operating costs for two successive fiscal years.

(a) *First year adjustment.* The hospital's rural average standardized amount and disproportionate share payments as described in § 412.106 are adjusted on the basis of an additional amount that equals two-thirds of the difference between the urban standardized amount and disproportionate share payments applicable to the hospital before its reclassification and the rural standardized amount and disproportionate share payments otherwise applicable to the Federal fiscal year for which the adjustment is made.

(b) *Second year adjustment.* If a hospital continues to be reclassified as rural, its rural average standardized amount and disproportionate share payments are adjusted on the basis of an additional amount that equals one-third of the difference between the urban standardized amount and disproportionate share payments applicable to the hospital before its reclassification and the rural standardized amounts and disproportionate share payments otherwise applicable to the Federal fiscal year for which the adjustment is made.

[58 FR 46338, Sept. 1, 1993, as amended at 65 FR 47047, Aug. 1, 2000]

### **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.**

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

(1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at <http://www.nal.usda.gov/orph> or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of

Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in §412.96, or as a sole community hospital as set forth in §412.92, if the hospital were located in a rural area.

(b) *Application requirements.* (1) *Written application.* A hospital seeking reclassification under this section must submit a complete application in writing to CMS in accordance with paragraphs (b)(2) and (b)(3) of this section.

(2) *Contents of application.* An application is complete if it contains an explanation of how the hospital meets the condition that constitutes the basis of the request for reclassification set forth in paragraph (a) of this section, including data and documentation necessary to support the request.

(3) *Mailing of application.* An application must be mailed to the CMS Regional Office by the requesting hospital and may not be submitted by facsimile or other electronic means.

(4) *Notification by CMS.* Within 5 business days after receiving the hospital's application, the CMS Regional Office will send the hospital a letter acknowledging receipt, with a copy to the CMS Central Office.

(5) *Filing date.* The filing date of the application is the date CMS receives the application.

(c) *CMS review.* The CMS Regional Office will review the application and notify the hospital of its approval or disapproval of the request within 60 days of the filing date.

(d) *Effective dates of reclassification.* (1) Except as specified in paragraph (d)(2) of this section, CMS will consider a hospital that satisfies any of the criteria set forth in paragraph (a) of this section as being located in the rural area of the State in which the hospital is located as of that filing date.

(2) If a hospital's complete application is received in CMS by September 1, 2000, and satisfies any of the criteria set forth in paragraph (a) of this section,

CMS will consider the filing date to be January 1, 2000.

(e) *Withdrawal of application.* A hospital may withdraw an application at any time prior to the date of CMS's decision as set forth in paragraph (c) of this section.

(f) *Duration of classification.* An approved reclassification under this section remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(g) *Cancellation of classification.* (1) A hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of its current cost reporting period.

(2) The hospital's cancellation of the classification is effective beginning with the hospital's next full cost reporting period following the date of its request for cancellation.

[65 FR 47048, Aug. 1, 2000]

**§412.104 Special treatment: Hospitals with high percentage of ESRD discharges.**

(a) *Criteria for classification.* Effective with cost reporting periods that begin on or after October 1, 1984, CMS provides an additional payment to a hospital for inpatient dialysis provided to ESRD beneficiaries if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into DRG No. 302 (Kidney Transplant), DRG No. 316 (Renal Failure) or DRG No. 317 (Admit for Renal Dialysis), constitute ten percent or more of its total Medicare discharges.

(b) *Additional payment.* A hospital that meets the criteria of paragraph (a) of this section is paid an additional payment for each ESRD beneficiary discharge except those excluded under paragraph (a) of this section.

(1) The payment is based on the estimated weekly cost of dialysis and the average length of stay of ESRD beneficiaries for the hospital.

(2) The estimated weekly cost of dialysis is the average number of dialysis sessions furnished per week during the 12-month period that ended June 30, 1983 multiplied by the average cost of dialysis for the same period.

(3) The average cost of dialysis includes only those costs determined to be directly related to the dialysis service. (These costs include salary, employee health and welfare, drugs, supplies, and laboratory services.)

(4) The average cost of dialysis is reviewed and adjusted, if appropriate, at the time the composite rate reimbursement for outpatient dialysis is reviewed.

(5) The payment to a hospital equals the average length of stay of ESRD beneficiaries in the hospital, expressed as a ratio to one week, times the estimated weekly cost of dialysis multiplied by the number of ESRD beneficiary discharges except for those excluded under paragraph (a) of this section. This payment is made only on the Federal portion of the payment rate.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]

**§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.**

CMS makes an additional payment to hospitals for indirect medical education costs using the following procedures:

(a) *Basic data.* CMS determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent residents (except as limited under paragraph (f) and (h) of this section) to the number of beds (as determined under paragraph (b) of this section).

(i) Except for the special circumstances for Medicare GME affiliated groups and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section for cost reporting periods beginning on or after October 1, 1997, and for the special circumstances for closed hospitals or closed programs described in paragraph (f)(1)(ix) of this section for cost reporting periods beginning on or after October 1, 2002, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period after accounting for the cap on the number of allopathic and osteopathic full-time equivalent residents as described in paragraph (f)(1)(iv) of this section, and adding to the capped numerator any

dental and podiatric full-time equivalent residents.

(ii) The exception for new programs described in paragraph (f)(1)(vii) of this section applies to each new program individually for which the full-time equivalent cap may be adjusted based on the period of years equal to the minimum accredited length of each new program.

(iii) The exception for closed hospitals and closed programs described in paragraph (f)(1)(ix) of this section applies only through the end of the first 12-month cost reporting period in which the receiving hospital trains the displaced full-time equivalent residents.

(iv) In the cost reporting period following the last year the receiving hospital's full-time equivalent cap is adjusted for the displaced resident(s), the resident-to-bed ratio cap in paragraph (a)(1) of this section is calculated as if the displaced full-time equivalent residents had not trained at the receiving hospital in the prior year.

(2) The hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made under the provisions of § 412.106.

(b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. This count of available bed days excludes bed days associated with—

(1) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system;

(2) Beds in excluded distinct part hospital units;

(3) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services;

(4) Beds or bassinets in the healthy newborn nursery; and

(5) Custodial care beds;

(c) *Measurement for teaching activity.* The factor representing the effect of teaching activity on inpatient operating costs equals .405 for discharges occurring on or after May 1, 1986.

(d) *Determination of education adjustment factor.* Each hospital's education adjustment factor is calculated as follows:

(1) *Step one.* A factor representing the sum of 1.00 plus the hospital's ratio of full-time equivalent residents to beds, as determined under paragraph (a)(1) of this section, is raised to an exponential power equal to the factor set forth in paragraph (c) of this section.

(2) *Step two.* The factor derived from step one is reduced by 1.00.

(3) *Step three.* The factor derived from completing steps one and two is multiplied by 'c', and where 'c' is equal to the following:

(i) For discharges occurring on or after October 1, 1988, and before October 1, 1997, 1.89.

(ii) For discharges occurring during fiscal year 1998, 1.72.

(iii) For discharges occurring during fiscal year 1999, 1.6.

(iv) For discharges occurring during fiscal year 2000, 1.47.

(A) Each hospital receives an amount that is equal in the aggregate to the difference between the amount of payments made to the hospital if "c" equaled 1.6, rather than 1.47.

(B) The payment of this amount will not affect any other payments, determinations, or budget neutrality adjustments.

(v) For fiscal year 2001—

(A) For discharges occurring on or after October 1, 2000 and before April 1, 2001, 1.54.

(B) For discharges occurring on or after April 1, 2001 and before October 1, 2001, the adjustment factor is determined as if "c" equaled 1.66, rather than 1.54. This payment increase will not apply to discharges occurring after fiscal year 2001 and will not be taken into account in calculating the payment amounts applicable for discharges occurring after fiscal year 2001.

(vi) For discharges occurring during fiscal year 2002, 1.6.

(vii) For discharges occurring on or after October 1, 2002, 1.35.

(e) *Determination of payment amount.*

Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total DRG revenue for inpatient operating costs, as determined under paragraph (a)(2) of this section, by the applicable education adjustment factor derived in paragraph (d) of this section.

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:

(i) The resident must be enrolled in an approved teaching program. An approved teaching program is one that meets one of the following requirements:

(A) Is approved by one of the national organizations listed in §415.200(a) of this chapter.

(B) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(1) The Directory of Graduate Medical Education Programs published by the American Medical Association.

(2) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

(C) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(D) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

(ii) In order to be counted, the resident must be assigned to one of the following areas:

(A) The portion of the hospital subject to the prospective payment system.



(B) The outpatient department of the hospital.

(C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in § 413.86(f)(3) or § 413.86(f)(4) of this subchapter, as applicable, are met.

(iii)(A) Full-time equivalent status is based on the total time necessary to fill a residency slot. No individual may be counted as more than one full-time equivalent. If a resident is assigned to more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any areas of the hospital listed in paragraph (f)(1)(ii) of this section to the total time worked by the resident. A hospital cannot claim the time spent by residents training at another hospital. A part-time resident or one working in an area of the hospital other than those listed under paragraph (f)(1)(ii) of this section (such as a freestanding family practice center or an excluded hospital unit) would be counted as a partial full-time equivalent based on the proportion of time assigned to an area of the hospital listed in paragraph (f)(1)(ii) of this section, compared to the total time necessary to fill a full-time residency slot.

(B) The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.

(iv) Effective for discharges occurring on or after October 1, 1997, the total number of FTE residents in the fields of allopathic and osteopathic medicine in either a hospital or a nonhospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such FTE residents in the hospital (or, in the case of a hospital located in a rural area, effective for discharges occurring on or after April 1, 2000, 130 percent of that number) with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

(v) For a hospital's cost reporting periods beginning on or after October 1,

1997, and before October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident counts (subject to the requirements listed in paragraphs (f)(1)(ii)(C) and (f)(1)(iv) of this section) for that cost reporting period and the preceding cost reporting period. For a hospital's cost reporting periods beginning on or after October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident count (subject to the requirements set forth in paragraphs (f)(1)(ii)(C) and (f)(1)(iv) of this section) for that cost reporting period and the preceding two cost reporting periods. If a hospital qualified for an adjustment to the limit established under paragraph (f)(1)(iv) of this section for new medical residency programs created under paragraph (f)(1)(vii) of this section, the count of residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (f)(1)(v) for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph, for each new program started, the period of years equals the minimum accredited length for each new program. The period of years for each new program begins when the first resident begins training in each new program. Subject to the provisions of paragraph (f)(1)(ix) of this section, FTE residents that are displaced by the closure of either another hospital or another hospital's program are added to the FTE count after applying the averaging rules in this paragraph (f)(1)(v) for the receiving hospital for the duration of time that the displaced residents are training at the receiving hospital. Subject to the provisions of paragraph (f)(1)(x) of this section, effective for cost reporting periods beginning on or after April 1, 2000, FTE residents at an

urban hospital in a rural track program are included in the urban hospital's rolling average calculation described in this paragraph (f)(1)(v).

(vi) Hospitals that are part of the same Medicare GME affiliated group (as defined in §413.86(b) of this subchapter) may elect to apply the limit at paragraph (f)(1)(iv) of this section on an aggregate basis, as specified in §413.86(g)(7) of this chapter.

(vii) If a hospital establishes a new medical residency training program, as defined in §413.86(g)(13) of this subchapter, the hospital's full-time equivalent cap may be adjusted in accordance with the provisions of §§413.86(g)(6)(i) through (iv) of this subchapter.

(viii) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its full-time equivalent cap in accordance with the provisions of §413.86(g)(8) of this subchapter.

(ix) A hospital may receive a temporary adjustment to its full-time equivalent cap to reflect residents added because of another hospital's closure if the hospital meets the criteria specified in §§413.86(g)(9)(i) and (g)(9)(ii) of this subchapter. If a hospital that closes its residency training program agrees to temporarily reduce its FTE cap according to the criteria specified in §§413.86(g)(9)(i) and (g)(9)(iii)(B) of this subchapter, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in §§413.86(g)(9)(i) and (g)(9)(iii)(A) of this subchapter are met.

(x) An urban hospital that establishes a new residency program (as defined in §413.86(g)(13) of this subchapter), or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks in accordance with the applica-

ble provisions of §413.86(g)(12) of this subchapter.

(xi) Effective for discharges occurring in cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional FTEs to the extent that the additional residents would have been counted as primary care residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on maternity or disability leave or a similar approved leave of absence, in accordance with the provisions of §413.86(g)(10) of this subchapter.

(xii) For discharges occurring on or after October 1, 1997, a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who had been previously trained at a VA hospital and were subsequently transferred to the non-VA hospital, if the hospital meets the criteria and other provisions of §413.86(g)(11) of this subchapter.

(2) To include a resident in the full-time equivalent count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(i) A listing, by specialty, of all residents assigned to the hospital and providing services to the hospital during the cost reporting period.

(ii) The name and social security number of each resident.

(iii) The dates the resident is assigned to the hospital.

(iv) The dates the resident is assigned to other hospitals or other freestanding providers and any nonprovider setting during the cost reporting period.

(v) The proportion of the total time necessary to fill a residency slot that the resident is assigned to an area of the hospital listed under paragraph (f)(1)(ii) of this section.

(3) Fiscal intermediaries must verify the correct count of residents.

(g) *Indirect medical education payment for managed care enrollees.* For portions of cost reporting periods occurring on or after January 1, 1998, a payment is made to a hospital for indirect medical education costs, as determined under

paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a Medicare+Choice organization under title XVIII, Part C of the Act during the period, according to the applicable payment percentages described in §§413.86(d)(3)(i) through (d)(3)(v) of this subchapter.

[50 FR 12741, Mar. 29, 1985. Redesignated at 56 FR 43241, Aug. 30, 1991]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §412.105, see the List of Sections Affected, which appears in the Finding Aids section of the printed volume and on GPO Access.

**§412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.**

(a) *General considerations.* (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.

(i) The number of beds in a hospital is determined in accordance with §412.105(b).

(ii) For purposes of this section, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system and excludes patient days associated with—

(A) Beds in excluded distinct part hospital units;

(B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services; and

(C) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system.

(iii) The hospital's location, in an urban or rural area, is determined in accordance with the definitions in §412.62(f).

(2) The payment adjustment is applied to the hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment

rates for inpatient operating costs, excluding outlier payments for inpatient operating costs under subpart F of this part and additional payments made under the provisions of §412.105.

(b) *Determination of a hospital's disproportionate patient percentage.* (1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) Determines the number of covered patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A.

(3) *First computation: Cost reporting period.* If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

(5) *Disproportionate patient percentage.* The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a percentage. This is the hospital's disproportionate patient percentage, and is used in paragraph (c) of this section.

(c) *Criteria for classification.* A hospital is classified as a "disproportionate share" hospital under any of the following circumstances:

(1) The hospital's disproportionate patient percentage, as determined under paragraph (b)(5) of this section, is at least equal to one of the following:

(i) 15 percent, if the hospital is located in an urban area, and has 100 or more beds, or is located in a rural area and has 500 or more beds.

(ii) 30 percent for discharges occurring before April 1, 2001, and 15 percent for discharges occurring on or after April 1, 2001, if the hospital is located in a rural area and either has more than 100 beds and fewer than 500 beds or is classified as a sole community hospital under §412.92.

(iii) 40 percent for discharges before April 1, 2001, and 15 percent for discharges occurring on or after April 1, 2001, if the hospital is located in an urban area and has fewer than 100 beds.

(iv) 45 percent for discharges before April 1, 2001, and 15 percent for discharges occurring on or after April 1, 2001, if the hospital is located in a rural area and has 100 or fewer beds.

(2) The hospital is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients.

(d) *Payment adjustment.* (1) *Method of adjustment.* Subject to the reduction factor set forth in paragraph (e) of this section, if a hospital serves a disproportionate number of low-income patients, its DRG revenues for inpatient operating costs are increased by an adjustment factor as specified in paragraph (d)(2) of this section.

(2) *Payment adjustment factors.* (i) If the hospital meets the criteria of paragraph (c)(1)(i) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is as follows:

(1) For discharges occurring on or after April 1, 1990, and before January 1, 1991, 5.62 percent plus 65 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(2) For discharges occurring on or after January 1, 1991, and before October 1, 1993, 5.62 percent plus 70 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(3) For discharges occurring on or after October 1, 1993, and before October 1, 1994, 5.88 percent plus 80 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(4) For discharges occurring on or after October 1, 1994, 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(B) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is as follows:

(1) For discharges occurring on or after April 1, 1990, and before October 1, 1993, 2.5 percent plus 60 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(2) For discharges occurring on or after October 1, 1993, 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(ii) If the hospital meets the criteria of paragraph (c)(1)(ii) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital is classified as a rural referral center, for discharges prior to April 1, 2001, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent. For discharges occurring on or after April 1, 2001, the following applies:

(1) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(2) If the hospital's disproportionate patient percentage is greater than 19.3 percent and less than 30 percent, the payment adjustment factor is 5.25 percent.

(3) If the hospital's disproportionate patient percentage is greater than or equal to 30 percent, the applicable payment adjustment factor is 5.25 percent plus 60 percent of the difference between 30 percent and the hospital's disproportionate patient percentage.

(B) If the hospital is classified as a sole community hospital, for discharges prior to April 1, 2001, the payment adjustment factor is 10 percent. For discharges occurring on or after April 1, 2001, the following applies:

(1) If the hospital's disproportionate patient percentage is less than 19.3 percent, the adjustment factor is 2.5 percent plus 65 percent of the difference

between 15 percent and the hospital's disproportionate patient percentage.

(2) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent and less than 30 percent, the payment adjustment factor is 5.25 percent.

(3) If the hospital's disproportionate patient percentage is equal to or greater than 30 percent the applicable payment adjustment factor is 10 percent.

(C) If the hospital is classified as both a rural referral center and a sole community hospital, the payment adjustment factor is:

(1) For discharges occurring before April 1, 2001, the greater of—

(i) 10 percent; or

(ii) 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(2) For discharges occurring on or after April 1, 2001, the greater of the adjustments determined under paragraph (d)(2)(ii)(A) or (d)(2)(ii)(B) of this section.

(D) If the hospital is classified as a rural hospital and is not classified as either a sole community hospital or a rural referral center, and has 100 or more beds, for discharges prior to April 1, 2001, the payment adjustment factor is 4 percent. For discharges occurring on or after April 1, 2001, the following applies:

(1) If the hospital's disproportionate patient percentage is less than 19.3 percent the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(2) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent the applicable payment adjustment factor is 5.25 percent.

(iii) If the hospital meets the criteria of paragraph (c)(1)(iii) of this section, the payment adjustment factor is as follows:

(A) For discharges occurring before April 1, 2001, 5 percent.

(B) For discharges occurring on or after April 1, 2001:

(1) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(2) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section, the payment adjustment factor is as follows:

(A) For discharges occurring before April 1, 2001, 4 percent.

(B) For discharges occurring on or after April 1, 2001:

(1) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(2) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(e) *Reduction in payments beginning FY 1998.* The amounts otherwise payable to a hospital under paragraph (d) of this section are reduced by the following:

(1) For FY 1998, 1 percent.

(2) For FY 1999, 2 percent.

(3) For FY 2000, 3 percent.

(4) For FY 2001:

(i) For discharges occurring on or after October 1, 2000 and before April 1, 2001, 3 percent.

(ii) For discharges occurring on or after April 1, 2001 and before October 1, 2001, 1 percent.

(5) For FY 2002, 3 percent.

(6) For FYs 2003 and thereafter, 0 percent.

[54 FR 36494, Sept. 1, 1989, as amended at 55 FR 14283, Apr. 17, 1990; 55 FR 15174, Apr. 20, 1990; 55 FR 32088, Aug. 7, 1990; 56 FR 573, Jan. 7, 1991; 56 FR 9633, Mar. 7, 1991; 57 FR 39824, Sept. 1, 1992; 60 FR 45848, Sept. 1, 1995; 62 FR 46029, Aug. 29, 1997; 63 FR 41004, July 31, 1998; 65 FR 3139, Jan. 20, 2000; 65 FR 47108, Aug. 1, 2000; 66 FR 32193, June 13, 2001; 66 FR 39934, Aug. 1, 2001; 67 FR 50112, Aug. 1, 2002; 68 FR 45470, Aug. 1, 2003]

#### **412.107 Special treatment: Hospitals that receive an additional update for FYs 1998 and 1999.**

(a) *Additional payment update.* A hospital that meets the criteria set forth in paragraph (b) of this section receives the following increase to its applicable percentage amount set forth in §412.63 (p) and (q):

(1) For FY 1998, 0.5 percent.

(2) For FY 1999, 0.3 percent.

(b) *Criteria for classification.* A hospital is eligible for the additional payment update set forth in paragraph (a) of this section if it meets all of the following criteria:

(1) *Definition.* The hospital is not a Medicare-dependent, small rural hospital as defined in §412.108(a) and does not receive any additional payment under the following provisions:

(i) The indirect medical education adjustment made under §412.105.

(ii) The disproportionate share adjustment made under §412.106.

(2) *State criteria.* The hospital is located in a State in which the aggregate payment made under §412.112 (a) and (c) for hospitals described in paragraph (b)(1) of this section for their cost reporting periods beginning in FY 1995 is less than the allowable operating costs described in §412.2(c) for those hospitals.

(3) *Hospital criteria.* The aggregate payment made to the hospital under §412.112 (a) and (c) for the hospital's cost reporting period beginning in the fiscal year in which the additional payment update described in paragraph (a) of this section is made is less than the allowable operating cost described in §412.2(c) for that hospital.

[62 FR 46030, Aug. 29, 1997]

#### **§412.108 Special treatment: Medicare-dependent, small rural hospitals.**

(a) *Criteria for classification as a Medicare-dependent, small rural hospital.* (1) *General considerations.* For cost reporting periods beginning on or after April 1, 1990 and ending before October 1, 1994, or beginning on or after October 1, 1997 and ending before October 1, 2006, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in §412.63(b)) and meets all of the following conditions:

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(i) The hospital has 100 or fewer beds as defined in §412.105(b) during the cost reporting period.

(ii) The hospital is not also classified as a sole community hospital under §412.92.

(iii) At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits during the hospital's cost reporting period or periods as follows, subject to the provisions of paragraph (a)(1)(iv) of this section:

(A) The hospital's cost reporting period ending on or after September 30, 1987 and before September 30, 1988.

(B) If the hospital does not have a cost reporting period that meets the criterion set forth in paragraph (a)(1)(iii)(A) of this section, the hospital's cost reporting period beginning on or after October 1, 1986, and before October 1, 1987.

(C) At least two of the last three most recent audited cost reporting periods for which the Secretary has a settled cost report.

(iv) If the cost reporting period determined under paragraph (a)(1)(iii) of this section is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

(2) *Counting days and discharges.* In counting inpatient days and discharges for purposes of meeting the criteria in paragraph (a)(1)(iii) of this section, only days and discharges from acute care inpatient hospital stays are counted (including days and discharges from swing beds when used for acute care inpatient hospital services), but not including days and discharges from units excluded from the prospective payment system under §§412.25 through 412.30 or from newborn nursery units. For purposes of this section, a transfer as defined in §412.4(b) is considered to be a discharge.

(b) *Classification procedures.* (1) The fiscal intermediary determines whether a hospital meets the criteria specified in paragraph (a) of this section.

(2) A hospital must submit a written request along with qualifying documentation to its fiscal intermediary to be considered for MDH status based on

the criterion under paragraph (a)(1)(iii)(C) of this section.

(3) The fiscal intermediary will make its determination and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation.

(4) A determination of MDH status made by the fiscal intermediary is effective 30 days after the date the fiscal intermediary provides written notification to the hospital. An approved MDH status determination remains in effect unless there is a change in the circumstances under which the status was approved.

(5) The fiscal intermediary will evaluate on an ongoing basis, whether or not a hospital continues to qualify for MDH status. This evaluation includes an ongoing review to ensure that the hospital continues to meet all of the criteria specified in paragraph (a) of this section.

(6) If the fiscal intermediary determines that a hospital no longer qualifies for MDH status, the change in status will become effective 30 days after the date the fiscal intermediary provides written notification to the hospital.

(7) A hospital may reapply for MDH status following its disqualification only after it has completed another cost reporting period that has been audited and settled. The hospital must reapply for MDH status in writing to its fiscal intermediary and submit the required documentation.

(8) If a hospital disagrees with an intermediary's determination regarding the hospital's initial or ongoing MDH status, the hospital may notify its fiscal intermediary and submit other documentable evidence to support its claim that it meets the MDH qualifying criteria.

(9) The fiscal intermediary's initial and ongoing determination is subject to review under subpart R of Part 405 of this chapter. The time required by the fiscal intermediary to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for that review.

(c) *Payment methodology.* A hospital that meets the criteria in paragraph (a) of this section is paid for its inpatient

operating costs the sum of paragraphs (c)(1) and (c)(2) of this section.

(1) The Federal payment rate applicable to the hospital as determined under §412.63, subject to the regional floor defined in §412.70(c)(6).

(2) The amount, if any, determined as follows:

(i) For discharges occurring during the first three 12-month cost reporting periods that begin on or after April 1, 1990, 100 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the higher of the following:

(A) The hospital-specific rate as determined under §412.73.

(B) The hospital-specific rate as determined under §412.75.

(ii) For discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, and for discharges occurring on or after October 1, 1997 and before October 1, 2006, 50 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the higher of the following:

(A) The hospital-specific rate as determined under §412.73.

(B) The hospital-specific rate as determined under §412.75.

(d) *Additional payments to hospitals experiencing a significant volume decrease.*

(1) CMS provides for a payment adjustment for a Medicare-dependent, small rural hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (d)(2) of this section, a more than 5 percent decrease in its total inpatient discharges as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.

(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital must submit its request

no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement and it must—

(i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to circumstances beyond the hospital's control.

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income patients as determined under §412.106 and for indirect medical education costs as determined under §412.105).

(i) In determining the adjustment amount, the intermediary considers—

(A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization.

(ii) The intermediary makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.

(iii) The intermediary determination is subject to review under subpart R of part 405 of this chapter. The time required by the intermediary to review the request is considered good cause for granting an extension of the time limit



for the hospital to apply for that review.

[55 FR 15175, Apr. 20, 1990; 55 FR 32088, Aug. 7, 1990, as amended at 55 FR 36070, Sept. 4, 1990; 57 FR 39824, Sept. 1, 1992; 58 FR 46339, Sept. 1, 1993; 58 FR 67350, Dec. 21, 1993; 59 FR 45400, Sept. 1, 1994; 62 FR 46030, Aug. 29, 1997; 62 FR 52034, Oct. 6, 1997; 65 FR 47048, Aug. 1, 2000; 66 FR 32194, June 13, 2001; 66 FR 39932, Aug. 1, 2001; 67 FR 50112, Aug. 1, 2002]

**§412.109 Special treatment: Essential access community hospitals (EACHs).**

(a) *General rule.* For payment purposes, CMS treats as a sole community hospital any hospital that is located in a rural area as described in paragraph (b) of this section and that CMS designated as an EACH under section 1820(i)(1) of the Act as in effect on September 30, 1997, for as long as the hospital continues to comply with the terms, conditions, and limitations that were applicable at the time CMS designated the hospital as an EACH. The payment methodology for sole community hospitals is set forth at §412.92(d).

(b) *Location in a rural area.* For purposes of this section, a hospital is located in a rural area if it—

(1) Is located outside any area that is a Metropolitan Statistical Area as defined by the Office of Management and Budget or that has been recognized as urban under §412.62;

(2) Is not deemed to be located in an urban area under §412.63;

(3) Is not classified as an urban hospital for purposes of the standardized payment amount by CMS or the Medicare Geographic Classification Review Board; or

(4) Is not located in a rural county that has been redesignated to an adjacent urban area under §412.232.

(c) *Adjustment to the hospital-specific rate for rural EACHs experiencing increased costs.* (1) *General rule.* CMS increases the applicable hospital-specific rate of an EACH that it treats as a sole community hospital if, during a cost reporting period, the hospital experiences an increase in its Medicare inpatient operating costs per discharge that is directly attributable to activities related to its membership in a rural health network.

(2) *Request and documentation.* In order for a hospital to qualify for an in-

crease in its hospital-specific rate, it must meet the following criteria:

(i) The hospital must submit its request to its intermediary no later than 180 days after the date on the intermediary's notice of program reimbursement.

(ii) The request must include documentation specifically identifying the increased costs resulting from the hospital's participation in a rural health network and show that the increased costs during the cost reporting period will result in increased costs in subsequent cost reporting periods that are not already accounted for under the prospective payment system payment.

(iii) The hospital must show that the cost increases are incremental costs that would not have been incurred in the absence of the hospital's membership in a rural health network.

(iv) The hospital must show that the cost increases do not include amounts for start-up and one-time, nonrecurring costs attributable to its membership in a rural health network.

(3) *Intermediary recommendation.* The intermediary forwards the following material to CMS within 60 days of receipt from the hospital:

(i) The hospital's documentation and the intermediary's verification of that documentation.

(ii) The intermediary's analysis and recommendation of the request.

(iii) The hospital's Medicare cost report for the year in which the increase in costs occurred and the prior year.

(4) *CMS determination.* CMS determines, within 120 days of receiving all necessary information from the intermediary, whether an increase in the hospital-specific rate is warranted and, if it is, the amount of the increase. CMS grants an adjustment only if a hospital's Medicare inpatient operating costs per discharge exceed the hospital's hospital-specific rate. The adjusted hospital-specific rate cannot exceed the hospital's Medicare inpatient operating costs per discharge for the cost reporting period.

(d) *Termination of EACH designation.* If CMS determines that a hospital no longer complies with the terms, conditions, and limitations that were applicable at the time CMS designated the

hospital as an EACH, CMS will terminate the EACH designation of the hospital, effective with discharges occurring on or after 30 days after the date of the determination.

(e) *Review of CMS determination.* A determination by CMS that a hospital's EACH designation should be terminated, is subject to review under part 405, subpart R of this chapter, including the time limits for filing requests for hearings as specified in §§405.1811(a) and 405.1841(a)(1) and (b) of this chapter.

[58 FR 30669, May 26, 1993, as amended at 59 FR 45398, Sept. 1, 1994; 60 FR 45848, Sept. 1, 1995; 61 FR 21972, May 13, 1996; 62 FR 46030, Aug. 29, 1997]

### Subpart H—Payments to Hospitals Under the Prospective Payment Systems

#### §412.110 Total Medicare payment.

Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of the payments listed in §§412.112 through 412.115, reduced by the amounts specified in §412.120.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]

#### §412.112 Payments determined on a per case basis.

A hospital is paid the following amounts on a per case basis:

(a) The appropriate prospective payment rate for inpatient operating costs for each discharge as determined in accordance with subparts D, E, and G of this part.

(b) Effective for cost reporting periods beginning on or after October 1, 1991, the appropriate prospective payment rate for capital-related costs for each discharge as determined in accordance with subpart M of this part.

(c) The appropriate outlier payment amounts determined under subpart F of this part.

(d) Additional payments for new medical services and technologies determined under subpart F of this part.

[56 FR 43448, Aug. 30, 1991, as amended at 57 FR 39824, Sept. 1, 1992; 68 FR 45470, Aug. 1, 2003]

#### §412.113 Other payments.

(a) *Capital-related costs.* (1) *Payment.* Subject to the reductions described in paragraph (a)(2) of this section, payment for capital-related costs (as described in §413.130 of this chapter) for cost reporting periods beginning before October 1, 1991 is determined on a reasonable cost basis.

(2) *Reduction to capital-related payments.* (i) Except for sole community hospitals as defined in §412.92, the amount of capital-related payments for cost-reporting periods beginning before October 1, 1991 (including a return on equity capital as provided under §413.157 of this chapter) is reduced by—

(A) Three and one-half percent for payments attributable to portions of cost reporting periods occurring during Federal FY 1987;

(B) Seven percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 and before January 1, 1988;

(C) Twelve percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) in fiscal year 1988 occurring on or after January 1, 1988;

(D) Fifteen percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989 and beginning on or after January 1, 1990 and ending on or before September 30, 1991; and

(E) Ten percent for payments attributable to portions of cost-reporting periods occurring on or after October 1, 1991 and before the beginning of the hospital's first cost-reporting period beginning on or after October 1, 1991.

(ii) If a hospital's cost reporting period encompasses more than one Federal fiscal year, the reductions to capital-related payments are determined on a prorated monthly basis.

(3) For cost-reporting periods beginning on or after October 1, 1991, a hospital with a hospital-specific rate above the Federal capital rate is paid a hold-harmless payment for old capital determined in accordance with subpart M of this part.

(b) *Direct medical education costs.* (1) Payment for the direct medical education costs of interns and residents in

approved programs for cost reporting periods beginning prior to July 1, 1985, and for approved education activities of nurses and paramedical health professionals is made as described in §413.85 of this chapter.

(2) For cost reporting periods beginning on or after July 1, 1985, payment for the direct medical education costs of interns and residents in approved programs is made as described in §413.86 of this chapter.

(3) Except as provided in §413.86(c) of this chapter, for cost reporting periods during the prospective payment transition period, the costs of medical education must be determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate as provided in subpart E of this part.

(c) *Anesthesia services furnished by hospital or CAH employed nonphysician anesthetists or obtained under arrangements.* (1) For cost reporting periods beginning on or after October 1, 1984 through any part of a cost reporting period occurring before January 1, 1989, payment is determined on a reasonable cost basis for anesthesia services provided in the hospital or CAH by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologist's assistants) employed by the hospital or CAH or obtained under arrangements.

(2)(i) For cost reporting periods, or any part of a cost reporting period, beginning on or after January 1, 1989, through any part of a cost reporting period occurring before January 1, 1990, payment is determined on a reasonable cost basis for anesthesia services provided in a hospital or CAH by qualified nonphysician anesthetists employed by the hospital or CAH or obtained under arrangement, if the hospital or CAH demonstrates to its intermediary prior to April 1, 1989 that it meets the following criteria:

(A) The hospital or CAH is located in a rural area as defined in §412.62(f) and is not deemed to be located in an urban area under the provisions of §412.64(b)(3).

(B) The hospital or CAH must have employed or contracted with a qualified nonphysician anesthetist, as de-

fined in §410.66 of this chapter, as of January 1, 1988 to perform anesthesia services in that hospital or CAH. The hospital or CAH may employ or contract with more than one anesthetist; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.

(C) The hospital or CAH must provide data for its entire patient population to demonstrate that, during calendar year 1987, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 250 procedures. For purposes of this section, a *surgical procedure requiring anesthesia services* means a surgical procedure in which the anesthesia is administered and monitored by a qualified nonphysician anesthetist, a physician other than the primary surgeon, or an intern or resident.

(D) Each qualified nonphysician anesthetist employed by or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

(ii) To maintain its eligibility for reasonable cost payment under paragraph (c)(2)(i) of this section in calendar years after 1989, a qualified hospital or CAH must demonstrate prior to January 1 of each respective year that for the prior year its volume of surgical procedures requiring anesthesia service did not exceed 500 procedures; or, effective October 1, 2002, did not exceed 800 procedures.

(iii) A hospital or CAH that did not qualify for reasonable cost payment for nonphysician anesthetist services furnished in calendar year 1989 can qualify in subsequent years if it meets the criteria in paragraphs (c)(2)(i)(A), (B), and (D) of this section, and demonstrates to its intermediary prior to the start of the calendar year that it met these criteria. The hospital or CAH must provide data for its entire patient population to demonstrate that, during calendar year 1987 and the year immediately preceding its election of reasonable cost payment, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services

did not exceed 500 procedures, or, effective October 1, 2002, did not exceed 800 procedures.

(iv) For administrative purposes for the calendar years after 1990, the volume of surgical procedures for the immediately preceding year is the sum of the surgical procedures for the nine month period ending September 30, annualized for the twelve month period.

(d) *Organ acquisition.* Payment for organ acquisition costs incurred by hospitals with approved transplantation centers is made on a reasonable cost basis. The term “Organs” is defined in §486.302 of this chapter.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §412.113, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and on GPO Access.

#### §412.115 Additional payments.

(a) *Bad debts.* An additional payment is made to each hospital in accordance with §413.80 of this chapter for bad debts attributable to deductible and co-insurance amounts related to covered services received by beneficiaries.

(b) *Administration of blood clotting factor.* For discharges occurring on or after June 19, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, an additional payment is made to a hospital for each unit of blood clotting factor furnished to a Medicare inpatient who is a hemophiliac.

(c) *QIO photocopy and mailing costs.* An additional payment is made to a hospital in accordance with §466.78 of this chapter for the costs of photocopying and mailing medical records requested by a QIO.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 55 FR 15175, Apr. 20, 1990; 56 FR 43448, Aug. 30, 1991; 57 FR 39825, Sept. 1, 1992; 57 FR 47787, Oct. 20, 1992; 58 FR 46339, Sept. 1, 1993; 62 FR 46030, Aug. 29, 1997]

#### §412.116 Method of payment.

(a) *General rules.* (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge

based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before January 1, 2002) are made as described in §§413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after January 1, 2002, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the conditions of §412.604 are made as described in §412.632.

(4) For cost reporting periods beginning on or after October 1, 2002, payments for inpatient hospital services furnished by a long-term care hospital that meets the conditions for payment of §§412.505 through 412.511 are made as described in §412.521.

(b) *Periodic interim payments—(1) Criteria for receiving periodic interim payments.* Effective with claims received on or after July 1, 1987, a hospital that meets the criteria in §413.64(h) of this chapter may request in writing to receive periodic interim payments as described in this paragraph. A hospital that is receiving periodic interim payments also receives payment on this basis for inpatient hospital services furnished by its excluded psychiatric or rehabilitation unit.

(i) *Failure of intermediary to make prompt payment.* Beginning with claims received in April 1987, the hospital's fiscal intermediary does not meet the requirements of section 1816(c)(2) of the Act, which provides for prompt payment of claims under Medicare Part A, for three consecutive calendar months. The hospital may continue to receive periodic interim payments until the intermediary meets the requirements of section 1816 (c)(2) of the Act for three consecutive calendar months. For purposes of this paragraph, a hospital that is receiving periodic interim payments as of June 30, 1987 and meets the requirements of §413.64(h) of this chapter may continue to receive payment on this basis until the hospital's intermediary meets the requirements of section 1816(c)(2) of the Act for three

consecutive calendar months beginning with April 1987.

(ii) *Hospitals that serve a disproportionate share of low-income patients.* The hospital is receiving periodic interim payments as of June 30, 1987 and has a disproportionate share payment adjustment factor of at least 5.1 percent as determined under §412.106(c) for purposes of establishing the average standardized amounts for discharges occurring on or after October 1, 1986 and before October 1, 1987. The hospital's request must be made by a date prior to July 1, 1987, specified by the intermediary.

(iii) *Small rural hospitals.* The hospital is receiving periodic interim payments as of June 30, 1987, makes its request by a date prior to July 1, 1987, specified by the intermediary, and, on July 1, 1987, the hospital—

(A) Is located in a rural area as defined in §412.62(f); and

(B) Has 100 or fewer beds available for use.

(2) *Frequency of payment.* The intermediary estimates a hospital's prospective payments as described in paragraph (b)(3) of this section and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. Each payment is made two weeks after the end of a biweekly period of service, as described in §413.64(h)(5) of this chapter. These payments are subject to final settlement.

(3) *Amount of payment.* (i) The biweekly interim payment amount is based on the total estimated Medicare discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount as described in paragraph (b)(3)(ii) of this paragraph. These interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period.

(ii) For purposes of determining periodic interim payments under this paragraph, a hospital's estimated average prospective payment amount is computed as follows:

(A) If a hospital has no payment experience under the prospective payment system for operating costs, the

intermediary computes the hospital's estimated average prospective payment amount for operating costs by multiplying its payment rates as determined under §412.70(c), but without adjustment by a DRG weighting factor, by the hospital's case-mix index, and subtracting from this amount estimated deductibles and coinsurance.

(B) Effective for cost-reporting periods beginning on or after October 1, 1991, the intermediary computes a hospital's estimated average prospective payment amount for capital-related costs by multiplying its prospective payment rate as determined under §412.340 or §412.344(a), as applicable, and under §412.308 for cost reporting periods beginning on or after October 1, 2001 but without adjustment by a DRG weighting factor, by the hospital's case-mix index. The intermediary may take into account estimated additional payments per discharge under §412.348. If the hospital is paid under §412.344(a)(1), the intermediary includes an estimated payment for old capital costs per discharge.

(C) If a hospital has payment experience under the prospective payment system for operating costs, and, for cost reporting periods beginning on or after October 1, 1991, for inpatient capital-related costs, the intermediary computes a hospital's estimated average prospective payment amount for operating costs and capital-related costs based on that payment experience, adjusted for projected changes, and subtracts from this amount estimated deductibles and coinsurance.

(4) *Termination of periodic interim payments—(i) Request by the hospital.* A hospital receiving periodic interim payments may convert to payments on a per discharge basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates periodic interim payments if—

(A) A hospital no longer meets the requirements of §413.64(h);

(B) A hospital is receiving payment under the criterion in paragraph (b)(1)(i) of this section and the intermediary meets the prompt payment requirements of section 1816(c)(2) of the Act for three consecutive calendar months; or

(C) A hospital that is receiving payment under the criterion set forth in paragraph (b)(1)(iii) of this section no longer meets the criterion.

(iii) *Limitation on reelection.* If a hospital that is receiving periodic interim payments under the criterion set forth in paragraph (b)(1)(ii) or (b)(1)(iii) of this section is removed from that method of payment at its own request, it may reelect to receive periodic interim payments only under the criterion set forth in paragraph (b)(1)(i) of this section. However, if the hospital is removed from that method of payment by its intermediary because it no longer meets the requirements of §413.64(h) of this chapter, that hospital may subsequently reelect to receive periodic interim payments if it qualifies under the provisions of paragraph (b)(1)(ii) or (b)(1)(iii) of this section, subject to the requirements in §413.64(h) of this chapter.

(c) *Special interim payments for certain costs.* For capital-related costs for cost-reporting periods beginning before October 1, 1991 and the direct costs of medical education, which are not included in prospective payments but are reimbursed as specified in §§413.130 and 413.85 of this chapter, respectively, interim payments are made subject to final cost settlement. Interim payments for capital-related items for cost-reporting periods beginning before October 1, 1991 and the estimated cost of approved medical education programs (applicable to inpatient costs payable under Medicare Part A and for kidney acquisition costs in hospitals approved as renal transplantation centers) are determined by estimating the reimbursable amount for the year based on the previous year's experience and on substantiated information for the current year and divided into 26 equal biweekly payments. Each payment is made two weeks after the end of a biweekly period of services, as described in §413.64(h)(5) of this chapter. The interim payments are reviewed by the intermediary at least twice during the reporting period and adjusted if necessary.

(d) *Special interim payment for unusually long lengths of stay—(1) First interim payment.* A hospital that is not receiving periodic interim payments under

paragraph (b) of this section may request an interim payment after a Medicare beneficiary has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

(2) *Additional interim payments.* A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of this paragraph (d).

(e) *Outlier payment and additional payments for new medical services and technologies.* Payments for outlier cases and additional payments for new medical services and technologies (described in subpart F of this part) are not made on an interim basis. These payments are made based on submitted bills and represent final payment.

(f) *Accelerated payments—(1) General rule.* Upon request, an accelerated payment may be made to a hospital that is not receiving periodic interim payments under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the hospital.

(ii) Due to an exceptional situation, there is a temporary delay in the hospital's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* A hospital's request for an accelerated payment must be approved by the intermediary and CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by

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recoupment as hospital bills are processed or by direct payment by the hospital.

[53 FR 1627, Jan. 21, 1988, as amended at 53 FR 38532, Sept. 30, 1988; 54 FR 36495, Sept. 1, 1989; 56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992; 59 FR 36712, July 19, 1994; 59 FR 45400, Sept. 1, 1994; 66 FR 41387, Aug. 7, 2001; 67 FR 56049, Aug. 30, 2002; 68 FR 45470, Aug. 1, 2003]

### § 412.120 Reductions to total payments.

(a) *Deductible and coinsurance.* Subject to paragraph (a)(2) of this section, the total Medicare payments otherwise payable to a hospital are reduced by the applicable deductible and coinsurance amounts related to inpatient hospital services as determined in accordance with §§ 409.82, 409.83, and 409.87 of this chapter.

(b) *Payment by workers' compensation, automobile medical, no-fault or liability insurance or an employer group health plan primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan which is primary to Medicare pays in full or in part, the Medicare payment is determined in accordance with the following guidelines:

(1) If workers' compensation pays, in accordance with the applicable provisions of §§ 405.316 through 405.321 of this chapter.

(2) If automobile medical, no-fault, or liability insurance pays, in accordance with the applicable provisions of §§ 405.322 through 405.325 of this chapter.

(3) If an employer group health plan which is primary to Medicare pays for services to ESRD beneficiaries, in accordance with the applicable provisions of §§ 405.326 through 405.329 of this chapter.

(4) If an employer group health plan which is primary to Medicare pays for services to employees age 65-69 and their spouses age 65-69, in accordance with the applicable provisions of §§ 405.340 through 405.344 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 55 FR 36071, Sept. 4, 1990; 56 FR 573, Jan. 7, 1991; 57 FR 39825, Sept. 1, 1992]

## 42 CFR Ch. IV (10-1-03 Edition)

### § 412.125 Effect of change of ownership on payments under the prospective payment systems.

When a hospital's ownership changes, as described in § 489.18 of this chapter, the following rules apply:

(a) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments, as provided in § 412.112, and payments for hemophilia clotting factor costs under § 412.115(b), are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(2) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(b) Other payments under § 412.113 and payments for bad debts as described in § 412.115(a), are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

[50 FR 12741, Mar. 29, 1985, as amended at 56 FR 43449, Aug. 30, 1991]

### § 412.130 Retroactive adjustments for incorrectly excluded hospitals and units.

(a) *Hospitals for which adjustment is made.* The intermediary makes the payment adjustment described in paragraph (b) of this section for the following hospitals:

(1) A hospital that was excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(2), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.23(b)(8) of this part regarding the inpatient population the hospital

planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(2) A hospital that has a unit excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(2), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under § 412.30(a) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(3) A hospital that added new beds to its existing rehabilitation unit for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.30(c) regarding the inpatient population the hospital planned to treat in these new beds during that cost reporting period, if the inpatient population actually treated in the new beds during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(b) *Adjustment of payment.* (1) For cost reporting periods beginning before January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

(2) For cost reporting periods beginning on or after January 1, 2002, the

intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

[56 FR 43241, Aug. 30, 1991, as amended at 57 FR 39825, Sept. 1, 1992; 59 FR 45400, Sept. 1, 1994; 60 FR 45848, Sept. 1, 1995; 66 FR 41387, Aug. 7, 2001]

### Subparts I–J [Reserved]

### Subpart K—Prospective Payment System for Inpatient Operating Costs for Hospitals Located in Puerto Rico

SOURCE: 52 FR 33058, Sept. 1, 1987, unless otherwise noted.

#### § 412.200 General provisions.

Beginning with discharges occurring on or after October 1, 1987, hospitals located in Puerto Rico are subject to the rules governing the prospective payment system for inpatient operating costs. Except as provided in this subpart, the provisions of subparts A, B, C, F, G, and H of this part apply to hospitals located in Puerto Rico. Except for § 412.60, which deals with DRG classification and weighting factors, the provisions of subparts D and E, which describe the methodology used to determine prospective payment rates for inpatient operating costs for hospitals, do not apply to hospitals located in Puerto Rico. Instead, the methodology for determining prospective payment rates for inpatient operating costs for



## § 412.204

these hospitals is set forth in §§ 412.204 through 412.212.

[57 FR 39825, Sept. 1, 1992]

### § 412.204 Payment to hospitals located in Puerto Rico.

(a) *FY 1988 through FY 1997.* For discharges occurring on or after October 1, 1997, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 75 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(2) 25 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

(b) *FY 1998 and thereafter.* For discharges occurring on or after October 1, 1997, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 50 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(2) 50 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

[62 FR 46030, Aug. 29, 1997]

### § 412.208 Puerto Rico rates for Federal fiscal year 1988.

(a) *General rule.* CMS determines the Puerto Rico adjusted DRG prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal year 1988 for a prospective payment hospital. These rates are determined as described in paragraphs (b) through (i) of this section.

(b) *Determining target amounts.* For each hospital subject to the prospective payment system for inpatient operating costs, CMS determines the Medicare target amount, as described in § 413.40(c) of this chapter, for the hospital's cost reporting period beginning in fiscal year 1987. Revisions in the target amounts made subsequent

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to establishment of the standardized amounts under paragraph (d) of this section do not affect the standardized amounts.

(c) *Updating the target amounts for fiscal year 1988.* CMS updates each target amount determined under paragraph (b) of this section for fiscal year 1988 by prorating the applicable percentage increase (as defined in § 412.63(f) of this chapter) for fiscal year 1988 to the midpoint of fiscal year 1988 (April 1, 1988).

(d) *Standardizing amounts.* CMS standardizes the amount updated under paragraph (c) of this section for each hospital by—

(1) Adjusting for variations in case mix among hospitals;

(2) Excluding an estimate of indirect medical education costs;

(3) Adjusting for area variations in hospital wage levels; and

(4) Excluding an estimate of the payments for hospitals that serve a disproportionate share of low-income patients.

(e) *Computing urban and rural averages.* CMS computes separate discharge-weighted averages of the standardized amounts determined under paragraph (d) of this section for urban and rural hospitals in Puerto Rico.

(f) *Geographic classification.* (1) For purposes of this paragraph (e) of this section, the following definitions apply:

(i) The term *urban area* means a Metropolitan Statistical Area (MSA), as defined by the Executive Office of Management and Budget.

(ii) The term *large urban area* means an MSA with a population of more than 1,000,000.

(iii) The term *rural area* means any area outside an urban area.

(2) A hospital classified as rural is deemed to be urban and receives the urban Puerto Rico payment amount if the county in which it is located meets the following criteria:

(i) At least 95 percent of the perimeter of the rural county is contiguous with urban counties.

(ii) The county was reclassified from an urban area to a rural area after April 20, 1983, as described in § 412.62(f)(1)(iv).

(iii) At least 15 percent of employed workers in the county commute to the

central county of one of the adjacent MSAs.

(g) *Reducing for value of outlier payments.* CMS reduces each of the average standardized amounts determined under paragraphs (c) through (e) of this section by a proportion equal to the proportion (estimated by CMS) of the total amount of payments based on DRG prospective payment rates that are additional payments to hospitals located in Puerto Rico for outlier cases under subpart F of this part.

(h) *Computing Puerto Rico rates established under the prospective payment system for inpatient operating costs for urban and rural hospitals.* For each discharge classified within a DRG, CMS establishes a Puerto Rico prospective payment rate, as follows:

(1) For hospitals located in an urban area, the rate equals the product of—

(i) The average standardized amount (computed under paragraphs (c) through (g) of this section) for hospitals located in an urban area; and

(ii) The weighting factor determined under §412.60(b) for that DRG.

(2) For hospitals located in a rural area, the rate equals the product of—

(i) The average standardized amount (computed under paragraphs (c) through (g) of this section) for hospitals located in a rural area; and

(ii) The weighting factor determined under §412.60(b) for that DRG.

(i) *Adjusting for different area wage levels.* CMS adjusts the proportion (as estimated by CMS from time to time) of Puerto Rico rates computed under paragraph (h) of this section that are attributable to wages and labor-related costs, for area differences in hospital wage levels, by a factor (established by CMS) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (f) of this section) of the hospital compared to the national average hospital wage level.

[52 FR 33058, Sept. 1, 1987; 52 FR 35350, Sept. 18, 1987, as amended at 53 FR 38533, Sept. 30, 1988; 57 FR 39825, Sept. 1, 1992]

**§412.210 Puerto Rico rates for fiscal years after Federal fiscal year 1988.**

(a) *General rule.* (1) CMS determines the Puerto Rico adjusted prospective

payment rate for inpatient operating costs for each inpatient hospital discharge occurring in a Federal fiscal year after fiscal year 1988 that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

(2) The rate is determined for hospitals located in large urban, other urban, or rural areas within Puerto Rico, as described in paragraphs (b) through (e) of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in §412.208(f)(1) apply.

(2) For discharges occurring on or after October 1, 1988, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greatest number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final standards for classification of MSAs published in the FEDERAL REGISTER on January 3, 1980 (45 FR 956), and available from CMS, East High Rise Building, Room 132, 6325 Security Boulevard, Baltimore, Maryland 21207.

(3) For discharges occurring on or after October 1, 1988, for hospitals that consist of two or more separately located inpatient hospital facilities, the national adjusted prospective payment rate for inpatient operating costs is based on the geographic location of the hospital at which the discharge occurs.

(c) *Updating previous standardized amounts.* CMS computes separate average standardized amounts for hospitals in large urban, other urban, and rural areas within Puerto Rico equal to the respective average standardized amount computed for fiscal year 1988 under §412.208(e)—

## § 412.212

(1) Increased by the applicable percentage changes determined under § 412.63 (g) and (h); and

(2) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts to hospitals located in Puerto Rico attributable to outlier cases under subpart F of this part.

(d) *Computing Puerto Rico rates for large urban, other urban, and rural hospitals.* For each discharge classified within a DRG, CMS establishes for the fiscal year a Puerto Rico prospective payment rate for inpatient operating costs as follows:

(1) For hospitals located in a large urban or other urban area in Puerto Rico, the rate equals the product of—

(i) The average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a large urban or other urban area; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in a rural area in Puerto Rico, the rate equals the product of—

(i) The average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a rural area; and

(ii) The weighting factor (determined under § 412.60(b)) for that DRG.

(e) *Adjusting for different area wage levels.* CMS adjusts the proportion (as estimated by CMS from time to time) of Puerto Rico rates computed under paragraph (d) of this section that is attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the Puerto Rico average hospital wage level.

[52 FR 33058, Sept. 1, 1987, as amended at 53 FR 38533, Sept. 30, 1988; 57 FR 39825, Sept. 1, 1992; 62 FR 46030, Aug. 29, 1997]

### § 412.212 National rate.

(a) *General rule.* For purposes of payment to hospitals located in Puerto Rico, the national prospective payment

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rate for inpatient operating costs is determined as described in paragraphs (b) through (d) of this section.

(b) *Computing a national average standardized amount.* CMS computes a discharge-weighted average of the—

(1) National urban adjusted standardized amount determined under § 412.63(j)(1)(i); and

(2) National rural adjusted average standardized amount determined under § 412.63(j)(2)(i).

(c) *Computing a national rate.* For each discharge classified within a DRG, the national rate equals the product of—

(1) The national average standardized amount computed under paragraph (b) of this section; and

(2) The weighting factor (determined under § 412.60(b)) for that DRG.

(d) *Adjusting for different area wage levels.* CMS adjusts the proportion (as estimated by CMS from time to time) of the national rate computed under paragraph (c) of this section that is attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

[52 FR 33058, Sept. 1, 1987, as amended at 53 FR 38533, Sept. 30, 1988; 57 FR 39825, Sept. 1, 1992]

### § 412.220 Special treatment of certain hospitals located in Puerto Rico.

Subpart G of this part sets forth rules for special treatment of certain facilities under the prospective payment system for inpatient operating costs. The following sections in subpart G of this part do not apply to hospitals located in Puerto Rico:

(a) Section 412.92, sole community hospitals.

(b) Section 412.96, referral centers.

[52 FR 33058, Sept. 1, 1987, as amended at 57 FR 39825, Sept. 1, 1992]

## Subpart L—The Medicare Geographic Classification Review Board

SOURCE: 55 FR 36766, Sept. 6, 1990, unless otherwise noted.

CRITERIA AND CONDITIONS FOR  
REDESIGNATION**§412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.**

(a) *General.* (1) *Purpose.* Except as provided in paragraph (a)(5) of this section, an individual hospital may be redesignated from a rural area to an urban area, from a rural area to another rural area, or from an urban area to another urban area for the purposes of using the other area's standardized amount for inpatient operating costs, wage index value, or both.

(2) *Proximity.* Except as provided in paragraph (a)(3) of this section, to be redesignated to another rural area or an urban area, a hospital must demonstrate a close proximity to the area to which it seeks redesignation by meeting the criteria in paragraph (b) of this section, and submitting data requested under paragraph (c) of this section.

(3) *Special rules for sole community hospitals and rural referral centers.* To be redesignated under the special rules in this paragraph, a hospital must be a sole community hospital or a rural referral center as of the date of the MGCRB's review.

(i) A hospital that is a rural referral center, a sole community hospital, or both does not have to demonstrate a close proximity to the area to which it seeks redesignation.

(ii) If a hospital that is a rural referral center, a sole community hospital, or both qualifies for urban redesignation, it is redesignated to the urban area that is closest to the hospital. If the hospital is closer to another rural area than to any urban area, it may seek redesignation to either the closest rural or the closest urban area.

(iii) If a sole community hospital or rural referral center loses its special status as a result of redesignation, the hospital is considered to retain its special status for the purpose of applicability of the special rules in paragraph (a)(3) of this section.

(iv) A hospital that is redesignated under paragraph (a)(3) of this section may not be redesignated in the same

fiscal year under paragraph (a)(2) of this section.

(4) *Application of criteria.* In applying the numeric criteria contained in §§412.230(b)(1) and (2), (d)(2), (e)(1)(iii), and (e)(1)(iv) (A) and (B), rounding of numbers to meet the mileage or qualifying percentage standard is not permitted.

(5) *Limitations on redesignation.* The following limitations apply to redesignation:

(i) An individual hospital may not be redesignated to another area for purposes of the wage index if the pre-reclassified average hourly wage for that area is lower than the pre-reclassified average hourly wage for the area in which the hospital is located.

(ii) For redesignations effective in fiscal years 1997 and 1998 and 2002 and thereafter, a hospital may not be redesignated for purposes of the standardized amount if the area to which the hospital seeks redesignation does not have a higher standardized amount than the standardized amount the hospital currently receives.

(iii) A hospital may not be redesignated to more than one area.

(iv) An urban hospital that has been granted redesignation as rural under §412.103 cannot receive an additional reclassification by the MGCRB based on this acquired rural status as long as such redesignation is in effect.

(v) Beginning with wage index reclassification applications for FY 2003, if a hospital is already reclassified to a given geographic area for wage index purposes for a 3-year period, and submits an application for reclassification to the same area for either the second or third year of the 3-year period, that application will not be approved.

(b) *Proximity criteria.* A hospital demonstrates a close proximity with the area to which it seeks redesignation if one of the following conditions applies:

(1) The distance from the hospital to the area is no more than 15 miles for an urban hospital and no more than 35 miles for a rural hospital.

(2) At least 50 percent of the hospital's employees reside in the area.

(c) *Appropriate proximity data.* For redesignation to an area, the hospital must submit appropriate data relating to its proximity to that area.

(1) To demonstrate proximity to the area, the hospital must submit evidence of the shortest route over improved roads to the area and the distance of that route.

(2) For employee address data, the hospital must submit current payroll records that include information that establishes the home addresses by zip code of its employees.

(d) *Use of an area's standardized amount for inpatient operating costs.* (1) *Criteria.* To receive an area's standardized amount for inpatient operating costs, a hospital must demonstrate that its incurred costs are more comparable to the amount it would be paid if it were reclassified than the amount it would be paid under its current classification, and that it has the necessary geographic relationship (as specified in paragraphs (a) and (b) of this section) with the area to which it seeks redesignation.

(2) *Demonstrating comparable costs.* A hospital demonstrates that its costs are more comparable to the amount it would be paid if it were reclassified if the hospital's case mix adjusted cost per discharge is at least equal to its current rate plus 75 percent of the difference between that rate and the rate it would receive if it were reclassified.

(3) *Appropriate cost data.* For a standardized amount for inpatient operating costs change, the hospital must submit appropriate data as follows:

(i) For hospital-specific data, the hospital must provide data from its most recently settled and most recently filed cost report.

(ii) For data on other hospitals, the hospital must base its application on the most recent revisions to the prospective payment rates for inpatient operating costs, as published in the FEDERAL REGISTER.

(e) *Use of urban or other rural area's wage index—*(1) *Criteria for use of area's wage index.* Except as provided in paragraphs (e)(3) and (e)(4) of this section, to use an area's wage index, a hospital must demonstrate the following:

(i) The hospital's incurred wage costs are comparable to hospital wage costs in an urban or other rural area;

(ii) The hospital has the necessary geographic relationship as specified in paragraphs (a) and (b) of this section;

(iii) One of the following conditions apply:

(A) With respect to redesignations for Federal fiscal year 1994 through 2001, the hospital's average hourly wage is at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located; or

(B) With respect to redesignations for Federal fiscal year 2002 and later years, the hospital's average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent, and, in the case of a hospital located in an urban area, at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located; and

(iv) One of the following conditions apply:

(A) For redesignations effective before fiscal year 1999, the hospital's average hourly wage weighted for occupational categories is at least 90 percent of the average hourly wages of hospitals in the area to which it seeks redesignation.

(B) With respect to redesignations for fiscal year 1994 through 2001, the hospital's average hourly wage is equal to at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

(C) With respect to redesignations for fiscal year 2002 and later years, the hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 82 percent, and in the case of a hospital located in an urban area, at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

(2) *Appropriate wage data.* For a wage index change, the hospital must submit appropriate wage data as follows:

(i) For redesignations effective through FY 2002:

(A) For hospital-specific data, the hospital must provide data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(B) For data for other hospitals, the hospital must provide data concerning the average hourly wage in the area in which the hospital is located and the

average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(C) If the hospital is requesting reclassification under paragraph (e)(1)(iv)(B) of this section, the hospital must provide occupational-mix data to demonstrate the average occupational mix for each employment category in the area to which it seeks reclassification. Occupational-mix data can be obtained from surveys conducted by the American Hospital Association.

(ii) For redesignations effective beginning FY 2003:

(A) For hospital-specific data, the hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. However, for the limited purpose of qualifying for geographic reclassification based on wage data from cost reporting periods beginning prior to FY 2000, a hospital may request that its wage data be revised if the hospital is in an urban area that was subject to the rural floor for the period during which the wage data the hospital wishes to revise were used to calculate its wage index.

(B) For data for other hospitals, the hospital must provide a weighted 3-year average of the average hourly wage in the area in which the hospital is located and a weighted 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

(iii) For purposes of this paragraph (e)(2), if a new owner does not accept assignment of the existing hospital's provider agreement in accordance with §489.18 of this chapter, the hospital will be treated as a new provider with a new provider number. In this case, the wage data associated with the previous hospital's provider number cannot be used in calculating the new hospital's 3-year

average hourly wage. Once a new hospital has accumulated at least 1 year of wage data, it is eligible to apply for reclassification on the basis of those data.

(3) *Rural referral center exception.* If a hospital was ever a rural referral center, it does not have to demonstrate that it meets the criterion set forth in paragraph (e)(1)(iii) of this section concerning its average hourly wage.

(4) *Special dominating hospital exception.* The requirements of paragraph (e)(1)(i) and (e)(1)(iii) of this section do not apply if a hospital meets the following criteria:

(i) Its average hourly wage is at least 108 percent of the average hourly wage of all other hospitals in the area in which the hospital is located.

(ii) It pays at least 40 percent of the adjusted uninflated wages in the MSA.

(iii) It was approved for redesignation under this paragraph (e) for each year from fiscal year 1992 through fiscal year 1997.

[55 FR 36766, Sept. 6, 1990, as amended at 56 FR 25488, June 4, 1991; 57 FR 39825, Sept. 1, 1992; 59 FR 45399, Sept. 1, 1994; 60 FR 45848, Sept. 1, 1995; 62 FR 46031, Aug. 29, 1997; 63 FR 26357, May 12, 1998; 65 FR 47108, Aug. 1, 2000; 66 FR 39934, Aug. 1, 2001; 68 FR 45470, Aug. 1, 2003; 68 FR 45470, Aug. 1, 2003]

**§412.232 Criteria for all hospitals in a rural county seeking urban redesignation.**

(a) *Criteria.* For all hospitals in a rural county to be redesignated to an urban area, the following conditions must be met:

(1) The county in which the hospitals are located must be adjacent to the MSA or NECMA to which they seek redesignation.

(2) All hospitals in a rural county must apply for redesignation as a group.

(3) The hospitals must demonstrate that the rural county in which they are located currently meets the criteria for metropolitan character under paragraph (b) of this section and the wage criteria under paragraph (c) of this section.

(4) The hospitals may be redesignated only if one of the following conditions is met:

(i) The pre-reclassified average hourly wage for the area to which they seek

redesignation is higher than the pre-reclassified average hourly wage for the area in which they are currently located.

(ii) The standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are located.

(b) *Metropolitan character.* The group of hospitals must demonstrate that the county in which the hospitals are located meets the standards for redesignation to an MSA or an NECMA as an outlying county that were published in the FEDERAL REGISTER on March 30, 1990 (55 FR 12154) using Bureau of the Census data or Bureau of Census estimates made after 1990.

(c) *Wage criteria.* In applying the following numeric criteria, rounding of numbers to meet the qualifying percentages is not permitted.

(1) *Aggregate hourly wage.* The aggregate average hourly wage for all hospitals in the rural county must be equal to at least 85 percent of the average hourly wage in the adjacent urban area; or

(2) *Aggregate hourly wage weighted for occupational mix.* For redesignations effective before fiscal year 1999, the aggregate hourly wage for all hospitals in the rural county, weighted for occupational categories, is at least 90 percent of the average hourly wage in the adjacent urban area.

(d) *Appropriate data.* (1) *Metropolitan character.* (i) To meet the criteria in paragraph (b) of this section, the hospitals may submit data, estimates, or projections, made by the Bureau of the Census concerning population density or growth, or changes in designation of urban areas.

(ii) The MGCRB only considers data developed by the Bureau of the Census.

(2) *Appropriate wage data.* The hospitals must submit appropriate data as follows:

(i) For redesignations effective through FY 2002:

(A) For hospital-specific data, the hospitals must provide data from the CMS wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(B) For data for other hospitals, the hospitals must provide the following:

(1) The average hourly wage in the adjacent area, which is taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(2) Occupational-mix data to demonstrate the average occupational mix for each employment category in the adjacent area. Occupational-mix data can be obtained from surveys conducted by the American Hospital Association.

(ii) For redesignations effective beginning FY 2003:

(A) For hospital-specific data, the hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

(B) For data for other hospitals, the hospital must provide a weighted 3-year average of the average hourly wage in the area in which the hospital is located and a weighted 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

[55 FR 36766, Sept. 6, 1990, as amended at 57 FR 39826, Sept. 1, 1992; 58 FR 46339, Sept. 1, 1993; 59 FR 45399, Sept. 1, 1994; 60 FR 45849, Sept. 1, 1995; 62 FR 46031, Aug. 29, 1997; 66 FR 39934, Aug. 1, 2001]

**§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.**

(a) *General criteria.* For all prospective payment hospitals in an urban county to be redesignated to another urban area, the following conditions must be met:

(1) All hospitals in an urban county must apply for redesignation as a group.

(2) The county in which the hospitals are located must be adjacent to the urban area to which they seek redesignation.

(3) The county in which the hospitals are located must be part of the Consolidated Metropolitan Statistical Area (CMSA) that includes the urban area to which they seek redesignation.

(4) The hospitals may be redesignated only if one of the following conditions is met.

(i) The pre-reclassified average hourly wage for the area to which they seek redesignation is higher than the pre-reclassified average hourly wage for the area in which they are currently located.

(ii) The standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are currently located.

(b) *Wage criteria.* In applying the following numeric criteria, rounding of numbers to meet the qualifying percentages is not permitted.

(1) *Aggregate hourly wage.* The aggregate average hourly wage of all hospitals in the urban county must be at least 85 percent of the average hospital hourly wage in the MSA or NECMA to which the hospitals in the county seek reclassification; or

(2) *Aggregate hourly wage weighted for occupational mix.* For redesignations effective before fiscal year 1999, the aggregate average hourly wage for all hospitals in the county, weighted for occupational categories, is at least 90 percent of the average hourly wage in the adjacent urban area.

(c) *Standardized amount inpatient operating costs—(1) Criteria.* The urban hospitals must demonstrate that their average incurred costs are more comparable to the amount the hospitals would be paid if they were reclassified than the amount they would be paid under their current classification.

(2) *Demonstrating comparable costs.* The urban hospitals demonstrate that their costs are more comparable to the average amount they would be paid if they were reclassified if, on average, each hospital's case-mix adjusted cost per case is at least equal to the amount it would be paid under its current classification plus 75 percent of the difference between that amount and the amount the hospital would receive if it were reclassified.

(d) *Appropriate data.* (1) *Wage data.* The hospitals must submit appropriate wage data as provided for in § 412.230(e)(2).

(2) *Cost data.* The hospitals must submit appropriate data as provided for in § 412.230(d)(3).

[56 FR 25488, June 4, 1991, as amended at 57 FR 39826, Sept. 1, 1992; 58 FR 46339, Sept. 1, 1993; 60 FR 45849, Sept. 1, 1995; 62 FR 46031, Aug. 29, 1997]

**§ 412.235 Criteria for all hospitals in a State seeking a statewide wage index redesignation.**

(a) *General criteria.* For all prospective payment system hospitals in a State to be redesignated to a statewide wage index, the following conditions must be met:

(1) All prospective payment system hospitals in the State must apply as a group for reclassification to a statewide wage index through a signed single application.

(2) All prospective payment system hospitals in the State must agree to the reclassification to a statewide wage index through a signed affidavit on the application.

(3) All prospective payment system hospitals in the State must agree, through an affidavit, to withdrawal of an application or to termination of an approved statewide wage index reclassification.

(4) All hospitals in the State must waive their rights to any wage index classification that they would otherwise receive absent the statewide wage index classification, including a wage index that any of the hospitals might have received through individual geographic reclassification.

(5) New hospitals that open within the State prior to the deadline for submitting an application for a statewide wage index reclassification (September 1), regardless of whether a group application has already been filed, must agree to the use of the statewide wage index as part of the group application. New hospitals that open within the State after the deadline for submitting a statewide wage index reclassification application or during the approved reclassification period will be considered a party to the statewide wage index application and reclassification.



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### (b) *Effect on payments.*

(1) An individual hospital within the State may receive a wage index that could be higher or lower under the statewide wage index reclassification in comparison to its otherwise redesignated wage index.

(2) Any new prospective payment system hospital that opens in the State during the effective period of an approved statewide wage index reclassification will be designated to receive the statewide wage index for the duration of that period.

### (c) *Terms of the decision.*

(1) A decision by the MGCRB on an application for a statewide wage index reclassification will be effective for 3 years beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the hospitals filed a complete application.

(2) The procedures and timeframes specified in § 412.273 apply to withdrawals of applications for redesignation to a statewide wage index and terminations of approved statewide wage index reclassifications, including the requirement that, to withdraw an application or terminate an approved reclassification, the request must be made in writing by all hospitals that are party to the application, except hospitals reclassified into the State for purposes of receiving the statewide wage index.

[66 FR 39935, Aug. 1, 2001]

## § 412.236 **Alternative criteria for hospitals located in an NECMA.**

(a) *General.* (1) An urban hospital whose designation is affected by the implementation of NECMAs may qualify for redesignation by meeting either the criteria in § 412.230 or the criterion in paragraph (b) of this section.

(2) All the hospitals in a NECMA may qualify for redesignation by meeting the criteria in either § 412.234 or in paragraph (c) of this section.

(b) *Criterion applicable to an individual urban hospital in a NECMA.* The hospital demonstrates that it would have been designated in a different urban area under the criteria for designating MSAs in New England.

(c) *Criteria applicable to a group of hospitals in a NECMA.* (1) All prospective

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payment hospitals in a NECMA must apply for redesignation.

(2) The hospitals must demonstrate that the NECMA to which they are designated would be combined as part of the NECMA to which they seek redesignation if the criteria for combining NECMAs were the same as the criteria used for combining MSAs.

(d) *Appropriate data.* (1) The MGCRB only considers population and commuting data developed by the Bureau of the Census.

(2) To meet the criterion in paragraph (b) of this section or the criteria in paragraph (c) of this section, hospitals must submit data from the Bureau of the Census.

[55 FR 36766, Sept. 6, 1990. Redesignated and amended at 56 FR 25488, June 4, 1991]

### COMPOSITION AND PROCEDURES

## § 412.246 **MGCRB members.**

(a) *Composition.* The Medicare Geographical Classification Review Board (MGCRB) consists of five members, including a Chairman, all of whom are appointed by the Secretary. The members include two members who are representative of prospective payment system hospitals located in rural areas, and at least one individual who is knowledgeable in analyzing the costs of inpatient hospital services.

(b) *Term of office.* The term of office for an MGCRB member may not exceed 3 years. A member may serve more than one term. The Secretary may terminate a member's tenure prior to its full term.

[55 FR 36766, Sept. 6, 1990, as amended at 61 FR 46224, Aug. 30, 1996; 61 FR 51217, Oct. 1, 1996]

## § 412.248 **Number of members needed for a decision or a hearing.**

(a) *A quorum.* A quorum, consisting of at least a majority of the MGCRB members, one of whom is representative of rural hospitals if possible, is required for making MGCRB decisions.

(b) *Number of members for a hearing.* If less than a quorum is present for an oral hearing, the chairman with the consent of the hospital may allow those members present to conduct the hearing and to prepare a recommended

decision, which is then submitted to a quorum.

**§412.250 Sources of MGCRB's authority.**

(a) *Compliance.* The MGCRB, in issuing decisions under section 1886(d)(10)(C) of the Act, complies with all the provisions of title XVIII and related provisions of the Act and implementing regulations, including the criteria and conditions located at §412.230 through §412.236, issued by the Secretary under the authority of section 1886(d)(10)(D) of the Act; and CMS Rulings issued under the authority of the Administrator.

(b) *Affords great weight.* The MGCRB affords great weight to other interpretive rules, general statements of policy and rules of agency organization, procedure, and practice established by CMS.

[55 FR 36766, Sept. 6, 1990, as amended at 56 FR 25488, June 4, 1991]

**§412.252 Applications.**

(a) *By one hospital.* An individual prospective payment system hospital seeking redesignation to a different rural or urban area has the right to submit an application to the MGCRB.

(b) *By a group of hospitals.* A group of hospitals has the right to submit an application to the MGCRB requesting redesignation of all prospective payment hospitals in a county if all prospective payment hospitals located in a county or in a NECMA agree to the request.

**§412.254 Proceedings before MGCRB.**

(a) *On-the-record decision.* The MGCRB will ordinarily issue an on-the-record decision without conducting an oral hearing. The MGCRB will issue a decision based upon all documents, data, and other written evidence and comments submitted timely to the MGCRB by the parties.

(b) *Oral hearing.* The MGCRB may hold an oral hearing on its own motion or if a party demonstrates to the MGCRB's satisfaction that an oral hearing is necessary.

**§412.256 Application requirements.**

(a) *Written application.* A request for reclassification must be in writing and

must constitute a complete application in accordance with paragraph (b) of this section.

(1) An application must be mailed or delivered to the MGCRB, with a copy to CMS, and may not be submitted through the facsimile (FAX) process or by other electronic means.

(2) A complete application must be received not later than the first day of the 13-month period preceding the Federal fiscal year for which reclassification is requested.

(3) The filing date of an application is the date the application is received by the MGCRB.

(b) *Criteria for a complete application.* An application is complete if the application from an individual hospital or from all hospitals in a county includes the following information:

(1) The Federal fiscal year for which the hospital is applying for redesignation.

(2) Which criteria constitute the basis of the request for reclassification.

(3) An explanation of how the hospital or hospitals meet the relevant criteria in §§412.230 through 412.236, including any necessary data to support the application.

(c) *Opportunity to complete a submitted application.* (1) The MGCRB will review an application within 15 days of receipt to determine if the application is complete. If the MGCRB determines that an application is incomplete, the MGCRB will notify the hospital, with a copy to CMS, within the 15 day period, that it has determined that the application is incomplete and may dismiss the application if a complete application is not filed by September 1.

(2) At the request of the hospital, the MGCRB may, for good cause, grant a hospital that has submitted an application by September 1, an extension beyond September 1 to complete its application.

(d) *Appeal of MGCRB dismissal.* (1) The hospital may appeal the MGCRB dismissal to the Administrator within 15 days of the date of the notice of dismissal.

(2) Within 20 days of receipt of the hospital's request for appeal, the Administrator will affirm the dismissal or reverse the dismissal and remand the

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case to the MGCRB to determine whether reclassification is appropriate.

(e) *Notification of complete application.* When the MGCRB determines that the hospital's application contains all the necessary elements for a complete application, it notifies the hospital in writing, with a copy to CMS, that the application is complete and that the case may proceed to an MGCRB decision.

[55 FR 36766, Sept. 6, 1990, as amended at 56 FR 25488, June 4, 1991; 62 FR 46031, Aug. 29, 1997; 63 FR 26357, May 12, 1998; 64 FR 41541, July 30, 1999]

## § 412.258 Parties to MGCRB proceeding.

(a) The party or parties to an MGCRB proceeding are the hospital or group of hospitals requesting a change in geographic designation.

(b) CMS has 30 days from the date of receipt of notice of a complete application to submit written comments and recommendations (with a copy to the hospital) for consideration by the MGCRB.

(c) The hospital has 15 days from the date of receipt of CMS's comments to submit written comments to the MGCRB, with a copy to CMS, for the purpose of responding to CMS's comments.

## § 412.260 Time and place of the oral hearing.

If the MGCRB decides that an oral hearing is necessary, it sets the time and place for the hearing and notifies the parties in writing, with a copy to CMS, not less than 10 days before the time scheduled for the hearing. The MGCRB may reschedule, adjourn, postpone, or reconvene the hearing provided that reasonable written notice is given to the parties, with a copy to CMS.

## § 412.262 Disqualification of an MGCRB member.

(a) *Grounds for disqualification.* An MGCRB member may not participate in any decision in a case in which he or she may be prejudiced or partial with respect to a party or has any other interest in the case.

(b) *Request for disqualification.* If a party believes that an MGCRB member

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should not participate in a decision, the party submits the objection in writing to the MGCRB at its earliest opportunity, explaining the grounds for the request. CMS may also submit such a suggestion to the MGCRB.

(c) *Consideration by the MGCRB member.* The MGCRB member will consider the objection and, at his or her discretion, either will proceed or withdraw.

(d) *Consideration by the MGCRB.* If the member does not withdraw, a party may petition the MGCRB for withdrawal and the MGCRB will consider the objection and rule on whether the member may participate in the decision before it decides the case.

## § 412.264 Evidence and comments in MGCRB proceeding.

(a) *Submission by the parties.* Before a decision is issued and during an oral hearing, the parties may present evidence or comments to the MGCRB regarding the matters at issue in the case.

(b) *Content of evidence and comments.* The MGCRB may receive evidence and comments without regard for the rules of evidence applicable to court procedures.

(c) *Ex parte communications.* (1) The members of the MGCRB and its staff may not consult or be consulted by an individual representing the interests of an applicant hospital or by any other individual on any matter in issue before the MGCRB without notice to the hospital or CMS. If such communication occurs, the MGCRB will disclose it to the hospital or CMS, as appropriate, and make it part of the record after the hospital or CMS has had an opportunity to comment. MGCRB members and staff may not consider any information outside the record about matters concerning a hospital's application for reclassification.

(2) The provisions in paragraph (c)(1) of this section do not apply to the following:

(i) Communications among MGCRB members and staff.

(ii) Communications concerning the MGCRB's administrative functions or procedures.

(iii) Requests from the MGCRB to a party or CMS for a document.

(iv) Material that the MGCRB includes in the record after notice and an opportunity to comment.

(d) *MGCRB rulings on evidence and comments.* The MGCRB rules upon the admissibility of evidence and comments and excludes irrelevant, immaterial, or unduly repetitious evidence and comments.

**§412.266 Availability of wage data.**

A hospital may obtain the average hourly wage data necessary to prepare its application to the MGCRB from FEDERAL REGISTER documents published in accordance with the provisions of §412.8(b).

[60 FR 45849, Sept. 1, 1995]

**§412.268 Subpoenas.**

(a) *In general.* When reasonably necessary for the full presentation of a case, and only after a pre-decision request for information or data has failed to produce the necessary evidence, either upon its own motion or upon the request of a party, the MGCRB may issue subpoenas for the attendance and testimony of witnesses, for an oral hearing or the production of books, records, correspondence, papers, or other documents that are relevant and material to any matter at issue.

(b) *Content of request.* The request must designate which witnesses or documents are to be produced, and describe addresses or locations with sufficient particularity to permit these witnesses or documents to be found. The request for a subpoena must state the pertinent facts that the party expects to establish by the requested witnesses or documents and whether these facts could be established by other evidence without the use of a subpoena.

(c) *Issuance.* Subpoenas are issued as provided in section 205(d) of the Act.

(d) *Payment for subpoena cost.* CMS pays for the cost of issuing subpoenas and the fees and mileage of any witness who is subpoenaed, as provided in section 205(d) of the Act.

**§412.270 Witnesses.**

Witnesses at an oral hearing testify under oath or affirmation, unless excused by the MGCRB for cause. The MGCRB may examine the witnesses

and may allow the parties or their representatives to also examine any witnesses called.

**§412.272 Record of proceedings before the MGCRB.**

A complete record of the proceedings before the MGCRB is made in all cases. The record will not be closed until a decision has been issued by the MGCRB. A transcription of an oral hearing will be made at a party's request, at the expense of the requesting party.

**§412.273 Withdrawing an application, terminating an approved 3-year reclassification, or canceling a previous withdrawal or termination.**

(a) *Timing of a withdrawal.* The MGCRB allows a hospital, or group of hospitals, to withdraw its application if the request for withdrawal is submitted to the MGCRB during the following time periods:

(1) At any time before the MGCRB issues a decision on the application; or

(2) After the MGCRB issues a decision, provided that the request for withdrawal is received by the MGCRB within 45 days of publication of CMS's annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the application has been filed.

(b) *Request for termination of approved 3-year wage index reclassifications.*

(1) A hospital, or a group of hospitals, that has been issued a decision on its application for a 3-year reclassification for wage index purposes only or for redesignation to a statewide wage index and has not withdrawn that application under the procedures specified in paragraph (a) of this section may request termination of its approved 3-year wage index reclassification under the following conditions:

(i) The request to terminate must be received by the MGCRB within 45 days of the publication of the annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the termination is to apply.

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(ii) A request to terminate a 3-year reclassification will be effective only for the full fiscal year(s) remaining in the 3-year period at the time the request is received. Requests for terminations for part of a fiscal year will not be considered.

(2) *Reapplication within the approved 3-year period.*

(i) If a hospital elects to withdraw its wage index application after the MGCRB has issued its decision, it may cancel its withdrawal in a subsequent year and request the MGCRB to reinstate its wage index reclassification for the remaining fiscal year(s) of the 3-year period.

(ii) A hospital may apply for reclassification for purposes of the wage index to a different area (that is, an area different from the one to which it was originally reclassified for the 3-year period). If the application is approved, the reclassification will be effective for 3 years. Once a 3-year reclassification becomes effective, a hospital may no longer cancel a withdrawal or termination of another 3-year reclassification, regardless of whether the withdrawal or termination request is made within 3 years from the date of the withdrawal or termination.

(iii) In a case in which a hospital with an existing 3-year wage index reclassification applies to be reclassified to another area, its existing 3-year reclassification will be terminated when a second 3-year wage index reclassification goes into effect for payments for discharges on or after the following October 1.

(c) *Written request only.* A request to withdraw an application or terminate an approved reclassification must be made in writing to the MGCRB by all hospitals that are party to the application or reclassification.

(d) *Process for canceling a previous withdrawal or termination.* A hospital may cancel a previous withdrawal or termination by submitting written notice of its intent to the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year, as specified in §412.256(a)(2).

(e) *Appeal of the MGCRB's denial of a hospital's request for withdrawal.* (1) A hospital may file an appeal of the

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MGCRB's denial of its request for withdrawal of an application to the Administrator. The appeal must be received within 15 days of the date of the notice of the denial.

(2) Within 20 days of receipt of the hospital's request for appeal, the Administrator affirms or reverses the denial.

[56 FR 25489, June 4, 1991, as amended at 56 FR 43241, Aug. 30, 1991; 57 FR 39826, Sept. 1, 1992; 66 FR 39935, Aug. 1, 2001; 67 FR 50113, Aug. 1, 2002]

#### §412.274 Scope and effect of an MGCRB decision.

(a) *Scope of decision.* The MGCRB may affirm or change a hospital's geographic designation. The MGCRB's decision is based upon the evidence of record, including the hospital's application and other evidence obtained or received by the MGCRB.

(b) *Effective date and term of the decision.*

(1) A standardized amount classification change is effective for one year beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the complete application is filed and ending effective at the end of that Federal fiscal year (the end of the next September 30).

(2) A wage index classification change is effective for 3 years beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year in which the complete application is filed.

[55 FR 36766, Sept. 6, 1990, as amended at 62 FR 46031, Aug. 29, 1997; 66 FR 39935, Aug. 1, 2001]

#### §412.276 Timing of MGCRB decision and its appeal.

(a) *Timing.* The MGCRB notifies the parties in writing, with a copy to CMS, and issues a decision within 180 days after the first day of the 13-month period preceding the Federal fiscal year for which a hospital has filed a complete application. The hospital has 15 days from the date of the decision to request Administrator review.

(b) *Appeal.* The decision of the MGCRB is final and binding upon the parties unless it is reviewed by the Administrator and the decision is changed

by the Administrator in accordance with §412.278.

[55 FR 36766, Sept. 6, 1990, as amended at 64 FR 41541, July 30, 1999]

**§412.278 Administrator's review.**

(a) *Hospitals requests for review.* A hospital or group of hospitals dissatisfied with the MGCRB's decision regarding its geographic designation may request the Administrator to review the MGCRB decision. (A hospital or group of hospitals may also request that the Administrator review the MGCRB's dismissal of an application as untimely filed or incomplete, as provided in §412.256(d).)

(b) *Procedures for hospital's request for review.* (1) The hospital's request for review must be in writing and sent to the Administrator, in care of the Office of the Attorney Advisor. The request must be received by the Administrator within 15 days after the date the MGCRB issues its decision. A request for Administrator review filed by facsimile (FAX) or other electronic means will not be accepted. The hospital must also mail a copy of its request for review to CMS's Office of Payment Policy.

(2) The request for review may contain proposed findings of fact and conclusions of law, exceptions to the MGCRB's decision, and supporting reasons therefor.

(3) Within 15 days of receipt of the hospital's request for review, CMS may submit to the Administrator, in writing, with a copy to the party, comments and recommendations concerning the hospital's submission.

(4) Within 10 days of receipt of CMS's submission, the hospital may submit in writing, with a copy to CMS, a response to the Administrator.

(c) *Discretionary review by the Administrator.* (1) The Administrator may, at his or her discretion, review any final decision of the MGCRB.

(2) The Administrator promptly notifies the hospital that he or she has decided to review a decision of the MGCRB. The notice of review indicates the particular issues to be considered and includes copies of any comments submitted to the Administrator by CMS staff concerning the MGCRB decision.

(3) Within 15 days of the receipt of the Administrator's notice of review, the hospital may submit a response in writing to the Administrator, with a copy of CMS.

(d) *Criteria for discretionary review.* In deciding whether to review an MGCRB decision, the Administrator normally considers whether it appears that any of the following situations apply:

(1) The MGCRB made an erroneous interpretation of law, regulation, or CMS Ruling.

(2) The MGCRB's decision is not supported by substantial evidence.

(3) The case presents a significant policy issue having a basis in law and regulations, and review is likely to lead to issuance of a CMS Ruling or other directive needed to clarify a provision in the law or regulations.

(4) The decision of the MGCRB requires clarification, amplification, or an alternative legal basis.

(5) The MGCRB has incorrectly extended its authority to a degree not provided for by law, regulation, or CMS Ruling.

(e) *Communication procedures.* All communications between CMS staff and the Administrator concerning the Administrator's review of an MGCRB decision must be in writing. As specified in paragraphs (b) and (c) of this section, copies of comments by CMS staff are sent to applicant hospitals within 15 days of receipt of a hospital's request for review, or, in cases in which the Administrator decides to review a case at his or her discretion, are included with the Administrator's notice of review. In the event there are additional communications between CMS staff and the Administrator concerning MGCRB decisions reviewed by the Administrator under paragraphs (b) or (c) of this section, CMS furnishes copies of the communications to the hospital or group of hospitals.

(f) *Administrator's decision.* (1) The Administrator may not receive or consider any new evidence and must issue a decision based only upon the record as it appeared before the MGCRB and comments submitted under paragraphs (b)(2), (b)(3), (b)(4), (c)(2), and (c)(3) of this section.

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(2) The Administrator issues a decision in writing to the party with a copy to CMS—

(i) Not later than 90 days following receipt of the party's request for review, except the Administrator may, at his or her discretion, for good cause shown, toll such 90 days; or

(ii) Not later than 105 days following issuance of the MGCRB decision in the case of review at the discretion of the Administrator.

(3) The Administrator's decision issued under § 412.278 (a) or (c) is the final Departmental decision, unless it is amended under § 412.278(g). The final Departmental decision is not subject to judicial review.

(4) The Administrator's decision is not subject to judicial review.

(g) *Amendment of Administrator decision*—(1) *Hospital's request for amendment.* The hospital may request the Administrator to amend the decision for the limited purpose of correcting mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The following procedure is followed:

(i) The hospital's request for amendment must be received by the Administrator within 10 days after the date the Administrator issues a decision. The request for amendment must be in writing, with a copy to CMS.

(ii) The Administrator promptly reviews the hospital's request and amends the decision, if necessary, within 5 days following receipt of the hospital's request for amendment.

(2) *Discretionary review by the Administrator.* Within 15 days following the issuance of the Administrator's decision, the Administrator, at his or her discretion, may amend the decision to correct mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The Administrator's amended decision is final and is not subject to judicial review.

[55 FR 36766, Sept. 6, 1990, as amended at 56 FR 25489, June 4, 1991; 57 FR 39826, Sept. 1, 1992; 68 FR 45471, Aug. 1, 2003]

## § 412.280 Representation.

(a) *General.* A party may be represented by legal counsel or by any other person appointed to act as its representative at any proceeding before the MGCRB or the Administrator.

(b) *Rights of a representative.* A representative appointed by a party may accept or give on behalf of the party any request or notice connected with any proceeding before the MGCRB or the Administrator. A representative is entitled to present evidence and argument as to facts and law in any MGCRB proceeding affecting the party represented and to obtain information to the same extent as the party represented. Notice of any action or decision sent to the representative of a party has the same effect as if it had been sent to the party itself.

## Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

SOURCE: 56 FR 43449, Aug. 30, 1991, unless otherwise noted.

### GENERAL PROVISIONS

## § 412.300 Scope of subpart and definition.

(a) *Purpose.* This subpart implements section 1886(g)(1)(A) of the Act by establishing a prospective payment system for inpatient hospital capital-related costs. Under this system, payment is made on the basis described in § 412.304 through § 412.374 for inpatient hospital capital-related costs furnished by hospitals subject to the prospective payment system under subpart B of this part.

(b) *Definition.* For purposes of this subpart, a new hospital means a hospital that has operated (under previous or present ownership) for less than 2 years. The following hospitals are not new hospitals:

(1) A hospital that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.

(2) A hospital that closes and subsequently reopens.

(3) A hospital that has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years.

(4) A hospital that changes its status from a hospital that is excluded from the prospective payment systems to a hospital that is subject to the capital prospective payment systems.

[56 FR 43449, Aug. 30, 1991, as amended at 57 FR 39827, Sept. 1, 1992]

**§412.302 Introduction to capital costs.**

(a) *New capital costs.* New capital costs are allowable Medicare inpatient hospital capital-related costs under subpart G of part 413 of this chapter that are related to assets that were first put in use for patient care after December 31, 1990 (except for such costs deemed to be old capital costs based on prior obligations as described in paragraph (c) of this section) and those allowable capital-related costs related to assets in use prior to December 31, 1990 that are excluded from the definition of old capital costs described in paragraphs (b) (2) through (5) of this section, or are betterment or improvement costs related to those old capital assets.

(b) *Old capital costs.* Except as provided in paragraph (c) of this section with respect to capital obligations that qualify for recognition as old capital, old capital costs are allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before December 31, 1990. However, for a new hospital as defined in §412.300(b), old capital costs are defined as those allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period under §412.328(a)(2). Old capital costs include the following:

(1) Allowable depreciation on assets based on the useful life guidelines used to determine depreciation expense in the hospital's base period.

(2) Allowable capital-related interest expense. Except as provided below, the amount of allowable capital-related interest expense that will be recognized as old capital is limited to the amount the hospital was legally obligated to

pay as of December 31, 1990. Any allowable interest expense in excess of this limitation will be recognized as new capital.

(i) An increase in interest expense is recognized if the increase is due to periodic fluctuations of rates in variable interest rate loans or at the time of conversion from a variable rate loan to a fixed rate loan when no other changes in the terms of the loan are made.

(ii) If the terms of a debt instrument are revised after December 31, 1990, the amount of interest that will be recognized as old capital during the transition cannot exceed the amount that would have been recognized during the same period prior to the revision of the debt instrument.

(iii) If short-term financing was used to acquire old capital assets and the debt is extended or "rolled-over", a portion of the extended debt will be recognized as old capital. The portion will equal the ratio of the net book value as of the beginning of the applicable cost reporting period for depreciable assets that were in use in the base year, to the net book value as of the beginning of the base year cost reporting period for those assets. The net book value for the base year will not be adjusted to exclude assets that have been fully depreciated or removed from service since the base year. If the debt is related to specific assets, the ratio will be determined based on the values for those assets. The ratio will exclude assets that were acquired with other identifiable debt instruments. For purposes of this paragraph, short term financing is a debt that becomes due in no later than the earlier of 5 years or half of the average useful life of the assets to which the debt is related.

(iv) If old capital indebtedness is commingled with new capital debt, the allowable interest expense will be apportioned to old capital costs based on the ratio of the portion of the loan principal related to old capital indebtedness to the total loan principal.

(v) Investment income, excluding income from funded depreciation accounts, is used to reduce old capital interest expense based on the ratio of total old capital interest expense to



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total allowable interest expense in each cost reporting period.

(3) Allowable capital-related lease and rental costs for land and depreciable assets that were obligated as of December 31, 1990.

(i) Lease renewals up to the annual lease payment level obligated as of December 31, 1990 are recognized provided the same asset remains in use, the asset has a useful life of at least 3 years, and the annual lease payment is \$1,000 or more for each item or service.

(ii) If a hospital-owned asset is sold or given to another party and that same asset is then leased back by the hospital, the amount of allowable capital-related costs recognized as old capital costs is limited to the amount allowed for that asset in the last cost reporting period that it was owned by the hospital.

(iii) If an entire hospital is leased without assumption of the hospital's asset costs after December 31, 1990, the amount of allowable capital-related costs recognized as old capital costs is limited to the amount allowed for old capital costs in the base year or the last cost reporting period these costs were recognized under this subpart, whichever is later.

(4) The portion of allowable costs for other capital-related expenses (including but not limited to, taxes, insurance, license and royalty fees on depreciable assets) resulting from applying the ratio of the hospital's gross old asset value to total asset value in each cost reporting period.

(5) The appropriate portion of the capital-related costs of related organizations under § 413.17 that would be recognized as old capital costs if these costs had been incurred directly by the hospital.

(6) Obligated capital costs that are recognized as old capital costs in accordance with paragraph (c) of this section.

(7) If a hospital had nonreimbursable costs applicable to an old capital asset as of December 31, 1990 that subsequently become allowable inpatient capital-related costs, the allowable costs for such an asset that are attributable to inpatient hospital services are recognized as old capital costs if a portion of the asset was in use for inpa-

tient hospital care on December 31, 1990 and the costs meet all other provisions for recognition of old capital costs contained in this section.

(c) *Obligated capital costs*—(1) *General rule*. Under the conditions described below, capital-related costs attributable to assets that are put in use after December 31, 1990 may be recognized as old capital costs. Any allowable capital-related costs for these assets that are not recognized as old capital costs are recognized as new capital costs.

(i) *Fixed assets*. The costs of capital-related items and services defined in subpart G of part 413 for which there was a contractual obligation entered into by a hospital or related party with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a fixed asset may be recognized as old capital costs if all the following conditions are met:

(A) The obligation must arise from a binding written agreement that was executed on or before December 31, 1990 and that obligates the hospital on or before December 31, 1990.

(B) The capital asset must be put in use for patient care before October 1, 1994 except as provided in paragraph (c)(1)(iv) of this section.

(C) The hospital notifies the intermediary of the existence of obligated capital costs as provided in paragraph (c)(1)(v) of this section.

(D) The amount that is recognized as old capital cost is limited to the lesser of the actual allowable costs when the asset is put in use or the estimated costs of the capital expenditure at the time it was obligated as provided in paragraph (c)(1)(vi) of this section.

(ii) *Moveable equipment*. Moveable equipment is recognized as old capital only if all of the conditions specified in paragraphs (c)(1)(i) (B) through (D) of this section are met and one of the following conditions is met:

(A) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for the lease or purchase of the item of equipment on or before December 31, 1990.

(B) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for financing the acquisition of the equipment; the item of equipment costs at least \$100,000; and the item was specifically listed in an equipment purchase plan approved by the Board of Directors on or before December 31, 1990.

(iii) *Agreements not recognized.* Agreements for planning, design or feasibility that do not commit the hospital to undertake a project are not recognized as obligating capital expenditures for purposes of this subsection.

(iv) *Extension of deadline.* CMS may extend the deadline in paragraph (c)(1)(i)(B) of this section, under which an asset must be put in use for patient care before October 1, 1994, to no later than September 30, 1996 for extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a construction strike or atypically severe weather that significantly delayed completion of a construction project. Normal construction delays do not constitute extraordinary circumstances.

(A) The hospital must submit its request for an extended deadline with documentation of the extraordinary circumstances by the later of January 1, 1993 or 180 days after the extraordinary circumstance.

(B) The intermediary reviews the request and verifies the hospital's documentation, and forwards the request to CMS within 60 days. Within 90 days, CMS notifies the intermediary of its decision and, if an extension is granted, of the revised deadline for putting the asset in use for patient care service.

(v) The hospital must submit to its intermediary the binding agreement and supporting documents that relate to the obligated capital expenditure by the later of October 1, 1992, or within 90 days after the start of the hospital's first cost reporting period beginning on or after October 1, 1991. This documentation must include a project description (including details of any phased construction or financing) and an estimate of costs that were prepared no later than December 31, 1990.

(vi) *Cost limitation—(A) Leases, Rentals or Purchases.* The amount of obligated capital costs recognized as old capital costs cannot exceed the amount specified in the lease, rental, or purchase agreement. If moveable equipment is recognized as old capital under paragraph (c)(1)(ii)(B) of this section, the amount recognized as old capital costs cannot exceed the estimated cost identified in the equipment purchase plan approved by the hospital's Board of Directors.

(B) *Construction contracts.* The amount of obligated capital costs recognized as old capital costs cannot exceed the estimated construction costs for the project as of December 31, 1990. Additional costs will be recognized as old capital costs only if the additional costs are directly attributable to changes in life safety codes or other building requirements established by government ordinance that occurred after the project was obligated.

(C) *Financing costs.* The amount of obligated interest expense that will be recognized as old capital costs cannot exceed the amount for which the hospital was legally obligated as of December 31, 1990 or, in the case of financing that is arranged after December 31, 1990 for a capital acquisition that was legally obligated as of December 31, 1990, the amount specified in a detailed financing plan approved by the hospital's Board of Directors prior to January 1, 1991.

(vii) *Determining old capital costs.* (A) The intermediary determines whether the applicable criteria are met for recognition of obligated capital costs as old capital costs and the maximum allowable cost that will be recognized as old capital costs.

(B) The intermediary advises the hospital of its determination by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification under paragraph (c)(1)(v) of this section.

(C) The actual amount that will be recognized as old capital costs is based on the lesser of the allowable costs for the asset when it is put into patient use or the amounts determined under paragraph (c)(1)(vi) of this section.

(viii) *Multi-phase project.* If the hospital has a multi-phase capital project, the provisions of paragraphs (c)(1) (i) through (vii) of this section apply independently to each phase of the project.

(2) *Lengthy certificate-of-need process.*

(i) If a hospital does not meet the criteria under paragraph (c)(1)(i) or paragraph (c)(1)(ii) of this section, but meets all of the following criteria, the estimated cost for the project as of December 31, 1990 may be recognized as old capital costs:

(A) The hospital is required under State law to obtain preapproval of the capital project or acquisition by a designated State or local planning authority in the State in which it is located.

(B) The hospital filed an initial application for a certificate of need on or before December 31, 1989 that includes a detailed description of the project and its estimated cost and had not received approval or disapproval on or before September 30, 1990. If the hospital received conditional approval on or before September 30, 1990, the hospital's intermediary assesses the nature of the conditions. The hospital will be considered to have received approval for the project as of September 30, 1990 if the intermediary determines that the hospital received sufficient approval for the project to proceed without significant delay.

(C) The hospital expended the lesser of \$750,000 or 10 percent of the estimated cost of the project on or before December 31, 1990; and

(D) The hospital put the asset into patient use on or before the later of September 30, 1996 or 4 years from the date the certificate of need was approved.

(ii) The provisions of paragraphs (c)(1) (iv) through (viii) of this section apply to projects that meet the criteria in paragraph (c)(2)(i) of this section.

(3) *Construction in process.* (i) If a hospital that initiates construction on a capital project does not meet the requirements of paragraphs (c)(1)(i) or (ii) or (c)(2)(i) of this section, the project costs may be recognized as old capital costs if all the following conditions are met:

(A) The hospital received any required certificate of need approval on or before December 31, 1990.

(B) The hospital's Board of Directors formally authorized the project with a detailed description of its scope and costs on or before December 31, 1990.

(C) The estimated cost of the project as of December 31, 1990 exceeds 5 percent of the hospital's total patient revenues during its base year.

(D) The capitalized cost that had been incurred for the project as of December 31, 1990 exceeded the lesser of \$750,000 or 10 percent of the estimated project cost.

(E) The hospital began actual construction or renovation ("groundbreaking") on or before March 31, 1991.

(F) The project is completed before October 1, 1994.

(ii) The provisions of paragraphs (c)(1) (iv) through (viii) of this section apply to projects that meet the criteria in paragraph (c)(3)(i) of this section.

(d) *Consistency in cost reporting—(1) General rule.* For cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001, the hospital must follow consistent cost finding methods for classifying and allocating capital-related costs, except as otherwise provided in paragraph (d)(4) of this section.

(2) *Old capital costs.* Unless there is a change of ownership, the hospital must continue the same cost finding methods for old capital costs, including its practices for the direct assignment of capital-related costs and its cost allocation bases, that were in effect in the hospital's last cost reporting period ending on or before October 1, 1991. If there is a change of ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices.

(3) *New capital costs.* If a hospital desires to change its cost finding methods for new capital costs, the request for change must be made in writing to the intermediary prior to the beginning of the cost reporting period for which the change is to apply. The request must include justification as to why the change will result in more accurate and more appropriate cost finding. The intermediary will not approve the change unless it determines that

there is reasonable justification for the change.

(4) Hospitals may elect the simplified cost allocation methodology under the terms and conditions provided in the instructions for CMS Form 2552.

[56 FR 43449, Aug. 30, 1991, as amended at 57 FR 3016, Jan. 27, 1992; 57 FR 39827, Sept. 1, 1992; 57 FR 46510, Oct. 9, 1992; 59 FR 45399, Sept. 1, 1994; 61 FR 46224, Aug. 30, 1996; 61 FR 51217, Oct. 1, 1996]

**§412.304 Implementation of the capital prospective payment system.**

(a) *General rule.* As described in §§412.312 through 412.370, effective with cost reporting periods beginning on or after October 1, 1991, CMS pays an amount determined under the capital prospective payment system for each inpatient hospital discharge as defined in §412.4. This amount is in addition to the amount payable under the prospective payment system for inpatient hospital operating costs as determined under §412.63.

(b) *Cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001.* For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, the capital payment amount is based on either a combination of payments for old capital costs and new capital costs or a fully prospective rate, as determined under §412.324 through §412.348.

(c) *Cost reporting periods beginning on or after October 1, 2001.*—(1) *General.* Except as provided in paragraph (c)(2) of this section, for cost reporting periods beginning on or after October 1, 2001, the capital payment amount is based solely on the Federal rate determined under §§412.308(a) and (b) and updated under §412.308(c).

(2) *Payment to new hospitals.* For cost reporting periods beginning on or after October 1, 2002—

(i) A new hospital, as defined under §412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost report ending at least 2 years after the hospital accepts its first patient, unless the new hospital elects to be paid under the capital prospective payment system based on 100 percent of the Federal rate.

(A) If the new hospital elects to be paid based on 100 percent of the Federal rate, the new hospital must submit a written request to the fiscal intermediary by the later of December 1, 2002 or 60 days before the beginning of its cost reporting period.

(B) Once a new hospital elects to be paid based on 100 percent of the Federal rate, it may not revert to payment at 85 percent of its allowable Medicare inpatient hospital capital-related costs.

(ii) For the third year and subsequent years, the hospital is paid based on the Federal rate as described under §412.312.

(d) *Interim payments.* Interim payments are made to the hospital as provided in §412.116.

[56 FR 43449, Aug. 30, 1991, as amended at 67 FR 50113, Aug. 1, 2002]

**BASIC METHODOLOGY FOR DETERMINING THE FEDERAL RATE FOR CAPITAL-RELATED COSTS**

**§412.308 Determining and updating the Federal rate.**

(a) *FY 1992 national average cost per discharge.* CMS determines the FY 1992 estimated national average cost per discharge by updating the discharge weighted national average Medicare inpatient hospital capital-related cost per discharge for FY 1989 by the estimated increase in Medicare inpatient hospital capital costs per discharge.

(b) *Standard Federal rate.* The standard Federal rate is used to determine the Federal rate for each fiscal year in accordance with the formula specified in paragraph (c) of this section.

(1) CMS determines the standard Federal rate by adjusting the FY 1992 updated national average cost per discharge by a factor so that estimated aggregate payments based on the standard Federal rate adjusted by the payment adjustments described in §412.312(b) equal estimated aggregate payments based solely on the national average cost per discharge.

(2) Effective FY 1994, the standard Federal rate used to determine the Federal rate each year under paragraph (c) of this section is reduced by 7.4 percent.

(3) Effective FY 1996, the standard Federal rate used to determine the

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Federal rate each year under paragraph (c) of this section is reduced by 0.28 percent to account for the effect of the revised policy for payment of transfers under § 412.4(d).

(4) Effective FY 1998, the unadjusted standard Federal capital payment rate in effect on September 30, 1997, used to determine the Federal rate each year under paragraph (c) of this section is reduced by 15.68 percent.

(5) For discharges occurring on or after October 1, 1997 through September 30, 2002, the unadjusted standard Federal capital payment rate as in effect on September 30, 1997, used to determine the Federal rate each year under paragraph (c) of this section is further reduced by 2.1 percent.

(6) For discharges occurring on or after October 1, 2002, the 2.1 percent reduction provided for under paragraph (b)(5) of this section is eliminated from the unadjusted standard Federal rate in effect on September 30, 2002, used to determine the Federal rate each year under paragraph (c) of this section.

(c) *The Federal rate.* CMS determines the Federal rate each year by adjusting the standard Federal rate by the following factors.

(1) *Update factor.* After FY 1992, CMS updates the standard Federal rate as follows:

(i) *FY 1993 through FY 1995.* For FY 1993 through FY 1995, the standard Federal rate is updated based on a moving two-year average of actual increases in capital-related costs per discharge for the period three and four years before the fiscal year in question, excluding the portion of the increase attributable to changes in case mix.

(ii) *Effective FY 1996.* Effective FY 1996, the standard Federal rate is updated based on an analytical framework. The framework includes a capital input price index, which measures the annual change in the prices associated with capital-related costs during the year. CMS adjusts the capital input price index rate of change to take into account forecast errors, changes in the case mix index, the effect of changes to DRG classification and relative weights, and allowable changes in the intensity of hospital services.

(2) *Outlier payment adjustment factor.* CMS reduces the updated standard Fed-

eral rate by an adjustment factor equal to the estimated additional payments under the Federal rate for outlier cases under subpart F of this part, determined as a proportion of total capital payments under the Federal rate.

(3) *Exceptions payment adjustment factor.* CMS reduces the updated standard Federal rate by an adjustment factor equal to the estimated additional payments for exceptions under § 412.348 determined as a proportion of total payments under the hospital-specific rate and Federal rate.

(4) *Budget neutrality adjustment factor.* (i) For FY 1992 through FY 1995, CMS adjusts the updated standard Federal rate by a budget neutrality factor determined under § 412.352.

(ii) CMS makes an adjustment to the Federal rate so that estimated aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual reclassification and recalibration of the DRG weight in accordance with § 412.60(e) and in the geographic adjustment factors described in § 412.312(b)(2) equal estimated aggregate payments based on the Federal rate that would have been made without such changes.

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992, as amended at 58 FR 46339, Sept. 1, 1993; 59 FR 45399, Sept. 1, 1994; 60 FR 45849, Sept. 1, 1995; 62 FR 46031, Aug. 29, 1997; 67 FR 50113, Aug. 1, 2002]

### § 412.312 Payment based on the Federal rate.

(a) *General.* The payment amount for each discharge based on the Federal rate determined under § 412.308(c) is determined under the following formula: [Federal rate×DRG weight×Geographic adjustment factor×Large urban add-on×(1+Capital disproportionate share adjustment factor + capital indirect medical education adjustment factor)×(for hospitals located in Alaska and Hawaii, a cost-of-living adjustment factor)]+(Any applicable outlier payment).

(b) *Payment adjustments—(1) DRG weights.* The relative resource requirements of the discharge are taken into account by applying the DRG weighting factor that is assigned to the discharge under § 412.60.

(2) *Geographic adjustment factors*—(i) *Local cost variation*. A geographic adjustment factor is applied that takes into account geographic variation in costs.

(ii) *Large urban add-on*. An additional adjustment is made for hospitals located in a large urban area to reflect the higher costs incurred by hospitals located in those areas.

(iii) *Cost-of-living adjustment*. An additional adjustment is made for hospitals located in Alaska and Hawaii to account for the higher cost-of-living in those States.

(3) *Disproportionate share adjustment*. For hospitals with at least 100 beds located in an urban area and serving low-income patients, a disproportionate share adjustment factor is applied that reflects the higher costs attributable to furnishing services to low income patients.

(4) *Indirect medical education adjustment*. An additional adjustment is made based on the ratio of residents to the average daily patient census of the hospital to account for the indirect costs of medical education.

(c) *Additional payment for outlier cases*. Payment is made for day outlier cases as provided for in § 412.82 and for cost outlier cases if both capital-related and operating-related costs exceed the cost outlier threshold as provided for in § 412.84.

(d) *Payment for transfer cases*. Payment is made for transfer cases as provided for in § 412.4.

(e) *Payment for extraordinary circumstances*. Payment for extraordinary circumstances is made as provided for in § 412.348(f) for cost reporting periods beginning on or after October 1, 2001.

[56 FR 43449, Aug. 30, 1991, as amended at 67 FR 50113, Aug. 1, 2002]

#### § 412.316 Geographic adjustment factors.

(a) *Local cost variation*. CMS adjusts for local cost variation based on the hospital wage index value that is applicable to the hospital under § 412.63(k). The adjustment factor equals the hospital wage index value applicable to the hospital raised to the .6848 power and is applied to 100 percent of the Federal rate.

(b) *Large urban location*. CMS provides an additional payment to a hospital located, for purposes of receiving payment under § 412.63(a), in a large urban area equal to 3.0 percent of what would otherwise be payable to the hospital based on the Federal rate.

(c) *Cost-of-living adjustment*. CMS provides an additional payment to a hospital located in Alaska and Hawaii equal to  $[(.3152 \times (\text{the cost-of-living adjustment factor used to determine payments under } § 412.115 - 1))] \text{ percent}$ .

#### § 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification*. A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b).

(2) The hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor*. (1) If a hospital meets the criteria in paragraph (a)(1) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals  $e$  raised to the power of  $(.2025 \times \text{the hospital's disproportionate patient percentage as determined under } § 412.106(b)(5)) - 1]$ , where  $e$  is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of hospital inpatient operating prospective payments, the disproportionate share adjustment factor is the factor that results from deeming the hospital to have the same disproportionate share patient percentage that would yield its operating disproportionate share adjustment.

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992, as amended at 58 FR 46339, Sept. 1, 1993]

#### § 412.322 Indirect medical education adjustment factor.

(a) *Basic data*. CMS determines the following for each hospital:

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(1) The hospital's number of full-time equivalent residents as determined under § 412.105(f).

(2) The hospital's average daily census is determined by dividing the total number of inpatient days in the acute inpatient area of the hospital by the number of days in the cost reporting period.

(3) The measurement of teaching activity is the ratio of the hospital's full-time equivalent residents to average daily census. This ratio cannot exceed 1.5.

(b) *Payment adjustment factor.* The indirect teaching adjustment factor equals  $[e \text{ (raised to the power of } .2822 \times \text{the ratio of residents to average daily census)} - 1]$ .

[56 FR 43449, Aug. 30, 1991, as amended at 63 FR 26357, May 12, 1998; 63 FR 41004, July 31, 1998]

#### DETERMINATION OF TRANSITION PERIOD PAYMENT RATES FOR CAPITAL-RELATED COSTS

#### § 412.324 General description.

(a) *Hospitals under Medicare in FY 1991.* During the ten-year transition period, payments to a hospital with a hospital-specific rate below the Federal rate are based on the fully prospective payment methodology under § 412.340 or for a hospital with a hospital-specific rate above the Federal rate, the hold-harmless payment methodology under § 412.344.

(b) *New hospitals.* (1) A new hospital, as defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost reporting period ending at least 2 years after the hospital accepts its first patient.

(2) For the third year through the remainder of the transition period, the hospital is paid based on the fully prospective payment methodology or the hold-harmless payment methodology using the base period determined under § 412.328(a)(2).

(3) If the hospital is paid under the hold-harmless methodology described in § 412.344, the hold-harmless payment for old capital costs described in § 412.344(a)(1) is payable for up to and including 8 years and may continue be-

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yond the first cost reporting period beginning on or after October 1, 2000.

(c) *Hospitals with 52-53 week fiscal years ending September 25 through September 29.* For purposes of this subpart, a hospital with a 52-53 week fiscal year period beginning September 26 through September 30, 1992 is deemed to have the same beginning date for all cost reporting periods beginning before October 1, 2000 (unless the hospital later changes its cost reporting period).

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992]

#### § 412.328 Determining and updating the hospital-specific rate.

(a) *Base-year cost reporting period.* (1) *Last 12 month cost reporting period ending on or before December 31, 1990.* For each hospital, the intermediary uses the hospital's latest 12-month or longer cost reporting period ending on or before December 31, 1990 as the base period to determine a hospital's hospital-specific rate.

(2) *New hospitals.* The base-year cost reporting period for a new hospital is its 12-month cost reporting period (or a combination of cost reporting periods covering at least 12 months) that begins at least 1 year after the hospital accepts its first patient.

(3) *Other hospitals.* For other than a new hospital as defined in § 412.300(b), if a hospital does not have a 12-month cost reporting period or does not have adequate Medicare utilization to file a cost report in a period ending on or before December 31, 1990, the hospital-specific rate is based on the hospital's old capital costs (per discharge) in its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) ending after December 31, 1990.

(b) *Base-year costs per discharge.* (1) *Base period allowable inpatient capital costs per discharge.* (i) *Determination.* The intermediary determines the base period allowable inpatient capital costs per discharge for the hospital by dividing the hospital's total allowable Medicare inpatient hospital capital-related cost in the base period by the number of Medicare discharges in the base period.

(ii) *Disposal of assets in the base year.* When a depreciable asset has been disposed of in the base year, only that portion of the gain or loss that is allocated to the base-year cost reporting period is reflected in the hospital-specific rate.

(iii) *Disposal of assets subsequent to the base year.* If an asset for which the Medicare program had recognized depreciation during the base year is disposed of subsequent to the base year, the hospital-specific rate will not be revised to recognize the portion of the gain or loss allocated to the base year.

(2) *Discharges.* For the purpose of determining a hospital's base period capital costs per discharge, a discharge includes discharges as defined in §412.4(a) and transfers as defined in §412.4(b)(2), adjusted by the transfer adjustment factor that is determined under paragraph (b)(3) of this section.

(3) *Transfer adjustment factor.* (i) For base year cost reporting periods ending on or before December 31, 1990, CMS uses the base year MEDPAR data received as of June 30, 1991 to develop an adjustment to discharges to account for transfers. CMS divides the length of stay for each transfer case by the geometric mean length of stay for the DRG (but in no case using a number greater than 1.0) and assigns each non-transfer case a value of 1.0. To determine the transfer adjustment factor, CMS adds together the adjusted discharges and divides the result by total discharges including transfers.

(ii) For base year cost reporting periods ending after December 31, 1990 but beginning before October 1, 1991, CMS determines a transfer adjustment factor as described in paragraph (b)(3)(i) of this section for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the approved base year.

(iii) For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer adjustment factor in place of CMS as described in paragraph (b)(3)(i) of this section based on the most recent billing data available as of the date of the final determination of the hospital-specific rate.

(c) *Case-mix adjustment.* (1) *Determining transfer-adjusted case mix value.* *Step 1:* For base year cost reporting periods ending on or before December 31, 1990, CMS uses the base year MEDPAR data received as of June 30, 1991 to determine the hospital's transfer-adjusted case-mix value. For base year cost reporting periods ending after December 31, 1990 and beginning before October 1, 1991, CMS determines a transfer-adjusted case-mix value for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the base year. For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer-adjusted case-mix value based on the most recent billing data available as of the date of the final determination of the hospital-specific rate. CMS or the intermediary, as appropriate, multiplies the DRG weight for each case by one of the following factors:

(i) If the case is not a transfer, the factor equals 1.0.

(ii) If the case is a transfer, the factor equals the lesser of 1.0 or the ratio of the length of stay for the case divided by the geometric mean length of stay for the DRG.

*Step 2:* The products derived for all cases under Step 1 are added together and the result is divided by the adjusted discharges used to calculate the transfer adjustment factor determined under paragraph (b)(3) of this section.

(2) *Adjusting base period capital costs per discharge by the hospital's transfer-adjusted case-mix value.* The intermediary divides the base period capital costs per discharge for each hospital as determined in paragraph (b) of this section by the hospital's transfer-adjusted case mix value for the cost reporting period determined under paragraph (c)(1) of this section.

(d) *Updating to FY 1992.* The intermediary updates the case-mix adjusted base period costs per discharge to FY 1992 based on the national average increase in Medicare inpatient capital costs per discharge as estimated by CMS, excluding the portion of the increase in capital costs per discharge attributable to changes in case mix.



(e) *Hospital-specific rate.* The intermediary determines the hospital-specific rate each year by adjusting the amount determined under paragraph (d) of this section by the following factors:

(1) *Update factor.* After FY 1992, the intermediary updates the hospital-specific rate in accordance with § 412.308(c)(1).

(2) *Exceptions payment adjustment factor.* For FY 1992 through FY 2001, the intermediary reduces the updated amount determined in paragraph (d) of this section by an adjustment factor equal to the estimated additional payments for capital-related costs for exceptions under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and Federal rate.

(3) *Budget neutrality adjustment factor.* For FY 1992 through FY 1995, the intermediary adjusts the updated amount determined in paragraph (d) of this section by a budget neutrality adjustment factor determined under § 412.352.

(4) *Payment for transfer cases.* Effective FY 1996, the intermediary reduces the updated amount determined in paragraph (d) of this section by 0.28 percent to account for the effect of the revised policy for payment of transfers under § 412.4(d).

(5) *Reduction of rate: FY 1998.* Effective FY 1998, the unadjusted hospital-specific rate as in effect on September 30, 1997 described in paragraph (e)(1) of this section is reduced by 15.68 percent.

(6) *Reduction of rate: FY 1998 through FY 2002.* For discharges occurring on or after October 1, 1997 through September 30, 2002, the unadjusted hospital-specific rate in effect on September 30, 1997, described in paragraph (e)(1) of this section is further reduced by 2.1 percent.

(f) *Redetermination of hospital-specific rate.* (1) *General.* (i) Upon request by a hospital, the intermediary redetermines the hospital-specific rate to reflect an increase in old capital costs as determined in a cost reporting period subsequent to the base year. An increase in Medicare old capital cost per discharge that is related solely to a decline in utilization is not recognized as an increase in old capital costs for purposes of this section. New capital costs

are excluded from the redetermination of the hospital-specific rate.

(ii) The hospital may request redetermination for any cost reporting period beginning subsequent to the base period but no later than the later of the hospital's cost reporting period beginning in FY 1994 or the cost reporting period beginning after obligated capital that is recognized as old capital under § 412.302(b) is put in use.

(iii) The hospital must request a redetermination in writing no later than the date the cost report must be filed with the hospital's intermediary for the first cost reporting period beginning on or after October 1, 1991 or the cost reporting period that will serve as the new base period, whichever is later. The hospital's redetermination request must include the cost report for the new base period and an estimate of the revised hospital-specific rate indicating that the new rate exceeds the hospital's current hospital-specific rate.

(2) *Determination of old capital costs.* The intermediary determines the hospital's old capital costs for the subsequent cost reporting period that will serve as the new base period. The intermediary includes the costs of obligated capital that are recognized as old capital costs under § 412.302(b), excludes the costs of assets disposed of subsequent to the initial base year, and reflects changes in allowable old capital costs occurring subsequent to the initial base period.

(3) *Redetermined hospital-specific rate.* The intermediary redetermines the hospital-specific rate based on the old capital costs that are determined under paragraph (f)(2) of this section for the new base period. The intermediary—

(i) Divides the hospital's old capital costs for the new base period by the number of Medicare discharges in that cost reporting period (consistent with paragraph (b) of this section);

(ii) Divides the old capital costs per discharge by the hospital's transfer adjusted case-mix value for the new base period (consistent with paragraph (c) of this section);

(iii) Applies an update factor, if appropriate, to account for inflation occurring subsequent to the new base

year, an exceptions payment adjustment factor, and a budget neutrality adjustment factor (consistent with paragraphs (d) and (e) of this section).

(4) *Denial by intermediary.* If the intermediary determines, after audit, that the revised hospital-specific rate is lower than the current hospital-specific rate, it advises the hospital that its request is denied and explains the basis for the denial.

(5) *Implementation date.* The redetermined hospital-specific rate applies to discharges occurring on or after the beginning date of the new base period.

(g) *Review and revision of the hospital-specific rate.* (1) *Interim determination.* The intermediary makes an interim determination of the hospital-specific rate based on the best data available and notifies the hospital at least 30 days before the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) *Final determination.* (i) The intermediary makes a final determination of the hospital-specific rate based on the final settlement of the base period cost report.

(ii) The final determination of the hospital-specific rate is effective retroactively to the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991 or, in the case of a redetermination of the hospital-specific rate under §412.328(f), to the beginning of the new base period.

(iii) The final determination of the hospital-specific rate is subject to administrative and judicial review in accordance with subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

(iv) The intermediary adjusts the hospital-specific rate to reflect any revisions that result from administrative or judicial review of the final determination of hospital-specific rate. The revised determination is effective retroactively to the same extent as in paragraph (g)(2)(ii) of this section.

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, 3017, Jan. 27, 1992; 57 FR 39828, Sept. 1, 1992; 60 FR 45849, Sept. 1, 1995; 62 FR 46031, Aug. 29, 1997]

**§412.331 Determining hospital-specific rates in cases of hospital merger, consolidation, or dissolution.**

(a) *New hospital merger or consolidation.* If, after a new hospital accepts its first patient but before the end of its base year, it merges with one or more existing hospitals, and two or more separately located hospital campuses are maintained, the hospital-specific rate and payment determination for the merged entity are determined as follows—

(1) *Post-merger base year payment methodology.* The new campus is paid based on reasonable costs until the end of its base year. The existing campus remains on its previous payment methodology until the end of the new campus' base year. Effective with the first cost reporting period beginning after the end of the new campus' base year, the intermediary determines a hospital-specific rate applicable to the new campus in accordance with §412.328, and then determines a revised hospital-specific rate for the merged entity in accordance with paragraph (a)(2) of this section.

(2) *Revised hospital-specific rate.* Using each hospital's base period data, the intermediary determines a combined average discharge-weighted hospital-specific rate.

(3) *Post-base year payment determination.* To determine the applicable payment methodology under §412.336 and for payment purposes under §412.340 or §412.344, the discharge-weighted hospital-specific rate determined by the intermediary is compared to the Federal rate. The revised payment methodology is effective on the first day of the cost reporting period beginning after the end of the new campus' base year.

(b) *Hospital merger or consolidation.* If, after the base year, two or more hospitals merge or consolidate into one hospital as provided for under §413.134(k) of this chapter and the provisions of paragraph (a) of this section do not apply, the intermediary determines a revised hospital-specific rate applicable to the combined facility under §412.328, which is effective beginning with the date of merger or consolidation. The following rules apply to the revised hospital-specific rate and payment determination:

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(1) *Revised hospital-specific rate.* Using each hospital's base period data, the intermediary determines a combined average discharge weighted hospital-specific rate.

(2) *Payment determination.* The discharge-weighted hospital-specific rate determined by the intermediary is compared to the Federal rate to establish the appropriate payment methodology under § 412.336 and for payment purposes under §§ 412.340 or 412.344. The revised payment methodology is effective as of the date of merger or consolidation.

(3) *Old capital cost determination.* The capital-related costs related to the assets of each merged or consolidated hospital as of December 31, 1990 are recognized as old capital costs during the transition period. If the hospital is paid under the hold-harmless methodology after merger or consolidation, only that original base year old capital is eligible for hold-harmless payments.

(c) *Hospital dissolution.* If a hospital separates into two or more hospitals that are subject to capital payments under this subpart after the base year, the intermediary determines new hospital-specific rates for each separate hospital under the provisions of § 412.328 effective as of the date of the dissolution. The new hospital-specific rates are determined as follows:

(1) *Hospital-specific rate—(i) Adequate base year data.* The intermediary determines whether the base year capital-related cost data and necessary statistical records are adequate to reconstruct the cost and other data required under § 412.328 from the former hospital's financial records to determine the hospital-specific rates for each facility. If the data are adequate, the intermediary uses the former hospital's base period to determine the hospital-specific rate for each separate hospital.

(ii) *Inadequate original base year data.* If the intermediary determines that the base period data for the former hospital is inadequate to establish separate hospital-specific rates, the intermediary establishes a new base period for each hospital. The new base period is each hospital's first 12-month or longer cost reporting period (or combination of cost reporting periods covering at least 12 months) immediately

following separation of the hospitals. The intermediary determines the hospital-specific rate for each hospital using the new base period under § 412.328.

(2) *Payment determinations.* The intermediary applies the payment methodology provisions of § 412.336. The revised payment determination is effective as of the date of the hospital's dissolution.

(3) *Old capital cost determination.* In determining the old capital costs for each hospital, the amount recognized as old capital is limited to the allowable capital-related costs attributable to assets that were in use for patient care as of December 31, 1990, and the hospitals are subject to all other transition period rules of this subpart.

[57 FR 39828, Sept. 1, 1992, as amended at 63 FR 41004, July 31, 1998]

### § 412.332 Payment based on the hospital-specific rate.

The payment amount for each discharge (as defined in § 412.4(a)) based on the hospital-specific rate determined under § 412.328 (e) or (f) is determined by multiplying the applicable hospital-specific rate by the DRG weighting factor applicable to the discharge under § 412.60 and the applicable hospital-specific rate percentage for the pertinent cost reporting period under § 412.340.

### § 412.336 Transition period payment methodologies.

(a) *General.* For discharges occurring in cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, a hospital is paid under one of two payment methodologies described in § 412.340 and § 412.344. Except as provided under paragraph (b) of this section, a hospital is paid under the same methodology throughout the transition period.

(1) *Hospital-specific rate below the Federal rate.* A hospital with a hospital-specific rate below the Federal rate (after taking into account the estimated effect of the payment adjustments and outlier payments) is paid under the fully prospective payment methodology as described in § 412.340.

(2) *Hospital-specific rate above the Federal rate.* A hospital with a hospital-specific rate that is above the Federal

rate (after taking into account the estimated effect of the payment adjustments and outlier payments) is paid under the hold-harmless payment methodology as described in § 412.344.

(b) *Special rule for revised hospital-specific rate.* If a hospital with a hospital-specific rate below the Federal rate requests that its hospital-specific rate be redetermined, the redetermined hospital-specific rate is compared to the Federal rate that is applicable to the new base period (after taking into account the estimated effect of the payment adjustments and outlier payments). If the redetermined hospital-specific rate is higher than the Federal rate, the hospital is paid under the hold-harmless methodology effective with the beginning of the new base period and continuing throughout the remainder of the transition.

(c) *Interim and final determinations of applicable payment methodology—(1) Interim determination.* The intermediary makes an interim determination of the applicable payment methodology based on the best data available and notifies the hospital of its determination at least 30 days before the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) *Final determination.* (i) The intermediary makes a final determination of the applicable payment methodology based on its final determination of the hospital's hospital-specific rate. The final determination of the applicable payment methodology is effective retroactively to the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991.

(ii) If the hospital-specific rate is redetermined in accordance with § 412.328(f), the intermediary makes a new determination of the applicable payment methodology. The new determination is effective retroactively to the beginning of the new base period.

(iii) If the hospital-specific rate is revised under § 412.328(g) as a result of administrative or judicial review, the intermediary makes a new determination of the applicable payment methodology. The new determination is effective retroactively to the beginning of the hospital's first cost reporting period beginning on or after October 1,

1991 or to the beginning of the new base period.

(d) *Special Rule for Redetermination of Hospital Payment Methodology.* For cost reporting periods beginning on or after October 1, 1993, the intermediary redetermines the hospital payment methodologies to take into account the reduction to the standard Federal rate provided in § 412.308(b)(2):

(1) For a hospital paid under the fully prospective payment methodology in the last hospital cost reporting period beginning before October 1, 1993, the intermediary compares the hospital's FY 1994 hospital-specific rate with the hospital's FY 1994 Federal rate (after taking into account the estimated effect of the payment adjustments and outlier payments).

(i) A hospital with a FY 1994 hospital-specific rate that is above the FY 1994 adjusted Federal rate is paid under the hold-harmless payment methodology described in § 412.344.

(ii) Subject to the provisions of § 412.328(f), a hospital with a FY 1994 hospital-specific rate that is below the FY 1994 adjusted Federal rate continues to be paid under the fully prospective payment methodology as described in § 412.340.

(iii) The intermediary notifies the hospital of the new determination of the hospital's payment methodology within 90 days of the hospital's first cost reporting period beginning on or after October 1, 1993. The new determination is effective to the beginning of the hospital's first cost reporting period beginning on or after October 1, 1993.

(2) A hospital paid under the hold-harmless payment methodology in the last cost reporting period beginning before October 1, 1993, will continue to be paid in accordance with the provisions of § 412.344.

[56 FR 43449, Aug. 30, 1991; 57 FR 3017, Jan. 27, 1992, as amended at 58 FR 46340, Sept. 1, 1993]

#### **§ 412.340 Fully prospective payment methodology.**

A hospital paid under the fully prospective payment methodology receives a payment per discharge based on a proportion of the hospital-specific rate and the Federal rate as follows:

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Cost reporting periods beginning on or after:	Federal rate percentage	Hospital-specific rate percentage
October 1, 1991 .....	10	90
October 1, 1992 .....	20	80
October 1, 1993 .....	30	70
October 1, 1994 .....	40	60
October 1, 1995 .....	50	50
October 1, 1996 .....	60	40
October 1, 1997 .....	70	30
October 1, 1998 .....	80	20
October 1, 1999 .....	90	10
October 1, 2000 .....	100	0

## § 412.344 Hold-harmless payment methodology.

(a) *General.* A hospital paid under the hold-harmless payment methodology receives a payment per discharge based on the higher of:

(1) 85 percent of reasonable costs for old capital costs (100 percent for sole community hospitals) plus an amount for new capital costs based on a proportion of the Federal rate. The proportion is equal to the ratio of the hospital's Medicare inpatient costs for new capital to total Medicare inpatient capital costs; or

(2) 100 percent of the Federal rate.

(3) *Exceptions.* (i) A hospital that would receive higher payment under paragraph (a)(1) of this section may elect payment based on 100 percent of the Federal rate under paragraph (a)(2) of this section.

(ii) A hospital that does not maintain records that are adequate to identify its old capital costs is deemed to have elected payment per discharge based on 100 percent of the Federal rate.

(b) *Continued basis of payment.* A hospital paid based on 100 percent of the Federal rate during the later of its cost reporting period beginning in FY 1994 or its first cost reporting period beginning after obligated capital that is recognized as old capital under § 412.302(b) is put in use continues to be paid on that basis in subsequent cost reporting periods during the transition period and does not receive a reasonable cost payment for old capital costs under paragraph (a)(1) of this section.

(c) *Basis of determination.* The determination under paragraph (a) of this section regarding which payment alternative is applicable is made without regard to additional payments under the exceptions process under § 412.348.

(d) *Interim and final payment determinations.* (1) Using the best data available, the intermediary makes an interim payment determination under paragraph (a) of this section concerning the applicable payment alternative, and, in the case of payment under paragraph (a)(1) of this section, the payment amounts for old and new capital. The intermediary notifies the hospital of its determination at least 30 days before the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991. The intermediary may revise its determination based on additional information submitted by the hospital and make appropriate adjustments retroactively.

(2) The final determination of the amount payable under paragraph (a) of this section is based on final settlement of the Medicare cost report for the applicable cost reporting period and is effective retroactively to the beginning of that cost reporting period. This final determination is subject to administrative and judicial review in accordance with subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

[56 FR 43449, Aug. 30, 1991; 57 FR 3017, Jan. 27, 1992]

## § 412.348 Exception payments.

(a) *Definitions.* As used in this section—

*Annual operating expenses.* Annual operating expenses means the sum of net expenses for all reimbursable cost centers for a 12 month cost reporting period. Annual operating expenses are obtained from the Medicare cost report.

*Average age of fixed assets.* The average age of fixed assets is the ratio of accumulated depreciation for buildings and fixed equipment to current depreciation expense for buildings and fixed equipment. The average age of fixed assets is determined from information on the Medicare cost report.

*Fixed assets.* Fixed assets mean buildings and fixed equipment.

(b) *Criterion for additional payment during the transition period.* An additional payment is made to a hospital paid under either the fully prospective payment methodology or the hold-

harmless payment methodology as determined under paragraph (c) of this section for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001.

(c) *Minimum payment level by class of hospital.* (1) CMS establishes a minimum payment level by class of hospital. The minimum payment level for a hospital will equal a fixed percentage of the hospital's capital-related costs. The minimum payment levels may be no greater than the percentages of allowable capital-related costs that follow:

(i) 90 percent for sole community hospitals.

(ii) 80 percent for hospitals located in an urban area for purposes of §412.63(a) with at least 100 beds, as determined under §412.105(b), that have a disproportionate share patient percentage of at least 20.2 percent as determined under §412.106(b), and for hospitals located in an urban area for purposes of §412.63(a) with at least 100 beds that qualify for disproportionate share payments under §412.106(c)(2).

(iii) 70 percent for all other hospitals.

(2) When it is necessary to adjust the minimum payment levels set by class of hospitals specified in paragraphs (c)(1)(i) and (g)(6) of this section, CMS will adjust those levels for each class of hospitals in one percentage point increments as necessary to satisfy the requirement specified in paragraph (h) of this section that total estimated payments under the exception process not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year.

(d) *Additional payments.* A hospital is entitled to an additional payment if its capital payments for the cost reporting period would otherwise be less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive minus any offset amount determined under paragraph (e)(2) of this section.

(e) *Determining a hospital's exception payment amount—(1) Cumulative comparison.* For each cost reporting period

beginning before October 1, 2001, the hospital's exception payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to the prospective payment system.

(2) *Offsetting amounts.* Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels is deducted from the additional payment that would otherwise be payable for a cost reporting period.

(f) *Additional payment exception for extraordinary circumstances.* (1) A hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of \$5 million (net of proceeds from other payment sources such as insurance, litigation decisions and other State, local or Federal government funding programs) due to extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a flood, fire, or earthquake.

(2) A hospital must apply to its CMS Regional Office by the later of October 1, 1992 or 180 days after the extraordinary circumstance causing the unanticipated expenditures for a determination by CMS of whether the hospital is eligible for an additional payment based on the nature of the circumstances and the amount of financial loss documented by the hospital.

(3) Except for sole community hospitals, the additional payment is based on a minimum payment amount of 85 percent for Medicare's share of allowable capital-related costs attributable to the extraordinary circumstances. For sole community hospitals, the minimum payment amount is 100 percent.

(4) The minimum payment level applicable under paragraph (c)(1) of this section is adjusted to take into account the 85 percent minimum payment level (100 percent for sole community hospitals) under paragraph (f)(3) of this section for the unanticipated capital-related costs. The additional payment for the cost reporting period equals the difference between the adjusted minimum payment level and the

capital payments the hospital would otherwise receive less any offset amount determined under paragraph (e)(2) of this section.

(g) *Special exceptions process.* For eligible hospitals that meet a project need requirement, a project size requirement, and, in the case of certain urban hospitals, meet an excess capacity test, an additional payment may be made for up to 10 years beyond the end of the capital prospective payment system transition period.

(1) *Eligible hospitals.* The following classes of hospitals are eligible to receive exceptions payments under this special exceptions provision:

(i) Sole community hospitals.

(ii) Hospitals located in an urban area under § 412.63(a) with at least 100 beds, as determined under § 412.105(b), that either have a disproportionate share of at least 20.2 percent as determined under § 412.106(b) or qualify for disproportionate share payments under § 412.106(c)(2).

(iii) Hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent.

(2) *Project need requirement.* A hospital must show that it has obtained any required approval from a State or local planning authority. If a hospital is not required to obtain approval from a planning authority, it must satisfy the age of asset test specified in paragraph (g)(3) of this section and, in the case of an urban hospital, the excess capacity test under paragraph (g)(4) of this section.

(3) *Age of assets test.* A hospital must show that its average age of fixed assets is at or above the 75th percentile for the hospital's first cost reporting period beginning on or after October 1, 1991.

(4) *Excess capacity test for urban hospitals.* Urban hospitals that are not required to receive approval from a State or local planning authority must demonstrate that either—

(i) The overall average occupancy rate in its metropolitan statistical area is at least 80 percent; or

(ii) After completion of the project, its capacity is no more than 80 percent of its prior capacity (in terms of bed size).

(5) *Project size requirement.* A hospital must complete, during the period from the beginning of its first cost reporting period beginning on or after October 1, 1991 to the end of its last cost reporting period beginning before October 1, 2001, a project whose costs for replacement and/or renovation of fixed assets related to patient care are at least:

(i) \$200 million; or

(ii) 100 percent of its operating cost during the first 12 month cost reporting period beginning on or after October 1, 1991.

(6) *Minimum payment level.*

(i) The minimum payment level for qualifying hospitals will be 70 percent.

(ii) CMS will adjust the minimum payment level in one percentage point increments as necessary to satisfy the requirement specified in paragraph (h) of this section that total estimated payments under the exceptions process not exceed 10 percent of the total estimated capital prospective payment system payments for the same fiscal year.

(7) *Limitation on the period for exception payments.* A qualifying hospital may receive an exceptions payment for up to 10 years from the year in which it completes a project for replacement or renovation of capital assets that meets project need and project size requirements (and, if applicable, excess capacity test), provided that it completes the project no later than the end of the hospital's last cost reporting period beginning before October 1, 2001. A project is considered to be completed when the assets are put into use for patient care.

(8) *Determining a hospital's exception payment amount—*(i) *Cumulative comparison.* For each cost reporting period, the hospital's exception payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to the prospective payment system.

(ii) *Offsetting amounts.* Offsetting amounts are applied in the following order—(A) Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels is deducted from the additional

payment that would otherwise be payable for a cost reporting period.

(B) Any amount by which the hospital's current year Medicare inpatient operating and capital prospective payment system payments (excluding, if applicable, 75 percent of the hospital's operating prospective payment system disproportionate share payments) exceed its Medicare inpatient operating and capital costs is deducted from the additional payment that would otherwise be payable for the cost reporting period. For purposes of calculating the offset, the costs and payments for services that are not subject to the hospital inpatient prospective payment system are excluded.

(9) *Notification requirement.* Eligible hospitals must submit documentation to the intermediary indicating the completion date of a project that meets the project need requirement under paragraph (g)(2) of this section, the project size requirement under paragraph (g)(5) of this section, and, in the case of certain urban hospitals, an excess capacity test under paragraph (g)(4) of this section, by the later of October 1, 2001 or within 3 months of the end of the hospital's last cost reporting period beginning before October 1, 2001, during which a qualifying project was completed.

(h) *Limit on exception payments.* Total estimated payments under the exception process may not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year.

[59 FR 45399, Sept. 1, 1994, as amended at 62 FR 46031, Aug. 29, 1997; 66 FR 39936, Aug. 1, 2001]

#### **§ 412.352 Budget neutrality adjustment.**

For FY 1992 through FY 1995, CMS will determine an adjustment to the hospital-specific rate and the Federal rate proportionately so that the estimated aggregate payments under this subpart for inpatient hospital capital costs each fiscal year will equal 90 percent of what CMS estimates would have been paid for capital-related costs on a reasonable cost basis under § 413.130 of this chapter.

#### **SPECIAL RULES FOR PUERTO RICO HOSPITALS**

#### **§ 412.370 General provisions for hospitals located in Puerto Rico.**

Except as provided in § 412.374, hospitals located in Puerto Rico are subject to the rules in this subpart governing the prospective payment system for inpatient hospital capital-related costs.

#### **§ 412.374 Payments to hospitals located in Puerto Rico.**

(a) Payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 50 percent of a Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 50 percent of the Federal rate, as determined under § 412.308.

(b) Effective for fiscal year 1998, the Puerto Rico capital rate described in paragraph (a) of this section in effect on September 30, 1997, is reduced by 15.68 percent.

(c) For discharges occurring on or after October 1, 1997 through September 30, 2002, the Puerto Rico capital rate described in paragraph (a) of this section in effect on September 30, 1997 is further reduced by 2.1 percent.

[62 FR 46032, Aug. 29, 1997]

#### **Subparts N [Reserved]**

#### **Subpart O—Prospective Payment System for Long-Term Care Hospitals**

SOURCE: 67 FR 56049, Aug. 30, 2002, unless otherwise noted.

#### **§ 412.500 Basis and scope of subpart.**

(a) *Basis.* This subpart implements section 123 of Public Law 106-113, which provides for the implementation of a prospective payment system for long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act. This subpart also reflects the provisions of section 307 of Public Law 106-554, which state that the Secretary shall examine



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and may provide for appropriate adjustments to that system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for long-term care hospitals, including the methodology used for the development of payment rates and associated adjustments and related rules. Under this system, for cost reporting periods beginning on or after October 1, 2002, payment for the operating and capital-related costs of inpatient hospital services furnished by long-term care hospitals is made on the basis of prospectively determined rates and applied on a per discharge basis.

### § 412.503 Definitions.

As used in this subpart—

*CMS* stands for the Centers for Medicare & Medicaid Services.

*Discharge.* A Medicare patient in a long-term care hospital is considered discharged when—

(1) For purposes of the long-term care hospital qualification calculation, as described in § 412.23(e)(3), the patient is formally released;

(2) For purposes of payment, as described in § 412.521(b), the patient stops receiving Medicare-covered long-term care services; or

(3) The patient dies in the long-term care facility.

*Long-term care hospital prospective payment system rate year* means the 12-month period of July 1 through June 30.

*LTC-DRG* stands for the diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes.

*Outlier payment* means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

*QIO* (formerly PRO or Peer Review Organization) stands for the Quality Improvement Organization.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34162, June 6, 2003]

### § 412.505 Conditions for payment under the prospective payment system for long-term care hospitals.

(a) *Long-term care hospitals subject to the prospective payment system.* To be eligible to receive payment under the prospective payment system specified in this subpart, a long-term care hospital must meet the criteria to be classified as a long-term care hospital set forth in § 412.23(e) for exclusion from the acute care hospital inpatient prospective payment systems specified in § 412.1(a)(1). This condition is subject to the special payment provisions of § 412.22(c), the provisions on change in hospital status of § 412.22(d), the provisions related to hospitals-within-hospitals under § 412.22(e), and the provisions related to satellite facilities under § 412.22(h).

(b) *General requirements.* (1) Effective for cost reporting periods beginning on or after October 1, 2002, a long-term care hospital must meet the conditions for payment of this section, § 412.22(e)(6) and (h)(5), and §§ 412.507 through § 412.511 to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

(2) If a long-term care hospital fails to comply fully with these conditions for payment with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may withhold (in full or in part) or reduce Medicare payment to the hospital.

### § 412.507 Limitation on charges to beneficiaries.

(a) *Prohibited charges.* Except as provided in paragraph (b) of this section, a long-term care hospital may not charge a beneficiary for any covered services for which payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment system. If Medicare has paid the full LTC-DRG payment, that payment applies to the hospital's costs for services furnished until the high-cost outlier threshold is met. If Medicare pays less than the full LTC-DRG payment, that payment only applies to the hospital's costs for those costs or days

used to calculate the Medicare payment.

(b) *Permitted charges.* (1) A long-term care hospital that receives a full LTC-DRG payment under this subpart for covered days in a hospital stay may charge the Medicare beneficiary only for the applicable deductible and coinsurance amounts under §§409.82, 409.83, and 409.87 of this subchapter, and for items and services as specified under §489.20(a) of this chapter.

(2) A long-term care hospital that receives less than the full LTC-DRG payment for a short-stay case, in accordance with §412.529, may only charge the Medicare beneficiary for the applicable deductible and coinsurance under §§409.82, 409.83, and 409.87 of this subchapter, for items and services as specified under §489.20(a) of this chapter, and for services provided during the stay that were not the basis for the short-stay payment.

**§412.508 Medical review requirements.**

(a) *Admission and quality review.* A long-term care hospital must have an agreement with a QIO to have the QIO review, on an ongoing basis, the following:

(1) The medical necessity, reasonableness, and appropriateness of hospital admissions and discharges.

(2) The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§412.523(d)(1) and 412.525(a).

(3) The validity of the hospital's diagnostic and procedural information.

(4) The completeness, adequacy, and quality of the services furnished in the hospital.

(5) Other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

(b) *Physician acknowledgement.* Payment under the long-term care hospital prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record. The hospital must assure that physicians complete an acknowledgement statement to this effect

in accordance with paragraphs (b)(1) and (b)(2) of this section.

(1) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

NOTICE TO PHYSICIANS: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(2) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(c) *Denial of payment as a result of admissions and quality review.*

(1) If CMS determines, on the basis of information supplied by a QIO, that a hospital has misrepresented admissions, discharges, or billing information, or has taken an action that results in the unnecessary admission or unnecessary multiple admissions of an individual entitled to benefits under Part A, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, CMS may, as appropriate—

(i) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided for an unnecessary admission or subsequent readmission of an individual; or

(ii) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(2) When payment with respect to admission of an individual patient is denied by a QIO under paragraph (c)(1) of this section, and liability is not waived

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in accordance with §§ 411.400 through 411.402 of this chapter, notice and appeals are provided under procedures established by CMS to implement the provisions of section 1155 of the Act, Right to Hearing and Judicial Review.

(3) A determination under paragraph (c)(1) of this section, if it is related to a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment system, is referred to the Department's Office of Inspector General for handling in accordance with § 1001.301 of this title.

### § 412.509 Furnishing of inpatient hospital services directly or under arrangement.

(a) Subject to the provisions of § 412.521(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following:

(1) Physicians' services that meet the requirements of § 415.102(a) of this subchapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioners and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this subchapter.

(b) Medicare does not pay any provider or supplier other than the long-term care hospital for services furnished to a Medicare beneficiary who is an inpatient of the hospital except for services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The long-term care hospital must furnish all necessary covered services to the Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements (as defined in § 409.3 of this subchapter).

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### § 412.511 Reporting and recordkeeping requirements.

A long-term care hospital participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§ 412.22(e)(6), 412.22(h)(5), 413.20, and 413.24 of this subchapter.

### § 412.513 Patient classification system.

(a) *Classification methodology.* CMS classifies specific inpatient hospital discharges from long-term care hospitals by long-term care diagnosis-related groups (LTC-DRGs) to ensure that each hospital discharge is appropriately assigned based on essential data abstracted from the inpatient bill for that discharge.

(b) *Assignment of discharges to LTC-DRGs.*

(1) The classification of a particular discharge is based, as appropriate, on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and the patient's discharge status.

(2) Each discharge from a long-term care hospital is assigned to only one LTC-DRG (related, except as provided in paragraph (b)(3) of this section, to the patient's principal diagnosis), regardless of the number of conditions treated or services furnished during the patient's stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill is returned to the hospital for validation and reverification. The LTC-DRG classification system provides a LTC-DRG, and an appropriate weighting factor, for those cases for which none of the surgical procedures performed are related to the principal diagnosis.

(c) *Review of LTC-DRG assignment.*

(1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a LTC-DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews that hospital's request and any additional information and decides whether a

change in the LTC-DRG assignment is appropriate. If the intermediary decides that a different LTC-DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in §476.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (c)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

#### §412.515 LTC-DRG weighting factors.

For each LTC-DRG, CMS assigns an appropriate weight that reflects the estimated relative cost of hospital resources used within that group compared to discharges classified within other groups.

#### §412.517 Revision of LTC-DRG group classifications and weighting factors.

CMS adjusts the classifications and weighting factors annually to reflect changes in—

- (a) Treatment patterns;
- (b) Technology;
- (c) Number of discharges; and
- (d) Other factors affecting the relative use of hospital resources.

#### §412.521 Basis of payment.

##### (a) *Method of payment.*

(1) Under the prospective payment system, long-term care hospitals receive a predetermined payment amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate established in accordance with §412.523, including adjustments described in §412.525, and, if applicable during a transition period, on a blend of the Federal payment rate and the cost-based reimbursement rate described in §412.533.

##### (b) *Payment in full.*

(1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance described in subpart G of part 409 of this subchapter) for covered inpatient operating costs as described in §412.2(c) and capital-related costs de-

scribed in subpart G of part 413 of this subchapter associated with furnishing Medicare covered services in long-term care hospitals.

(2) In addition to payment based on prospective payment rates, long-term care hospitals may receive payments separate from payments under the prospective payment system for the following:

(i) The costs of approved medical education programs described in §§413.85, 413.86, and 413.87 of this subchapter.

(ii) Bad debts of Medicare beneficiaries, as provided in §413.80 of this subchapter.

(iii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

(iv) Anesthesia services furnished by hospital employed nonphysician anesthesiologists or obtained under arrangements, as specified in §412.113(c)(2).

(v) The costs of photocopying and mailing medical records requested by a QIO, in accordance with §476.78(c) of this chapter.

(c) *Payment by workers' compensation, automobile medical, no-fault or liability insurance or an employer group health plan primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan that is primary to Medicare pays in full or in part, payment is determined in accordance with the guidelines specified in §412.120(b).

(d) *Effect of change of ownership on payments under the prospective payment system.* When a hospital's ownership changes, as described in §489.18 of this chapter, the following rules apply:

(1) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments as provided in §412.525 and payments for hemophilia clotting factor costs as provided in paragraph (b)(2)(iii) of this section, are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(i) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of

when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(ii) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(2) Other payments for the direct costs of approved medical education programs, bad debts, anesthesia services furnished by hospital employed nonphysician anesthesiologists, and costs of photocopying and mailing medical records to the QIO as provided for under paragraphs (b)(2)(i), (ii), (iv), and (v) of this section are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34162, June 6, 2003]

**§ 412.523 Methodology for calculating the Federal prospective payment rates.**

(a) *Data used.* To calculate the initial prospective payment rates for inpatient hospital services furnished by long-term care hospitals, CMS uses—

(1) The best Medicare data available; and

(2) A rate of increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient long-term care hospital services.

(b) *Determining the average costs per discharge for FY 2003.* CMS determines the average inpatient operating and capital-related costs per discharge for which payment is made to each inpatient long-term care hospital using the available data under paragraph (a)(1) of this section. The cost per discharge is adjusted to FY 2003 by a rate of increase factor, described in paragraph (a)(2) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(c) *Determining the Federal prospective payment rates.*

(1) *General.* The Federal prospective payment rates will be established using

a standard payment amount referred to as the standard Federal rate. The standard Federal rate is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor described in paragraph (a)(2) of this section to each hospital's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for FY 2003. Based on the updated cost per discharge, CMS estimates the payments that would have been made to each hospital for FY 2003 under Part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the standard Federal rate.* The standard Federal rate is computed as follows:

(i) *For FY 2003.* Based on the updated costs per discharge and estimated payments for FY 2003 determined in paragraph (c)(2) of this section, CMS computes a standard Federal rate for FY 2003 that reflects, as appropriate, the adjustments described in paragraph (d) of this section. The FY 2003 standard Federal rate is effective for discharges occurring in cost reporting periods beginning on or after October 1, 2002 through June 30, 2003.

(ii) *For long-term care hospital prospective payment system rate years beginning July 1, 2003 and after.* The standard Federal rate for long-term care hospital prospective payment system rate years beginning July 1, 2003 and after will be the standard Federal rate for the previous long-term care hospital prospective payment system rate year, updated by the increase factor described in paragraph (a)(2) of this section, and adjusted, as appropriate, as described in paragraph (d) of this section. For the rate year from July 1, 2003 through June 30, 2004, the updated and adjusted standard Federal rate will be offset by a budget neutrality factor to account for updating the FY 2003 standard Federal rate on July 1 rather than October 1.

(4) *Determining the Federal prospective payment rate for each LTC-DRG.* The Federal prospective payment rate for

each LTC-DRG is the product of the weighting factors described in § 412.515 and the standard Federal rate described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard Federal rate.* The standard Federal rate described in paragraph (c)(3) of this section will be adjusted for—

(1) *Outlier payments.* CMS adjusts the standard Federal rate by a reduction factor of 8 percent, the estimated proportion of outlier payments under the long-term care hospital prospective payment system, as described in § 412.525(a).

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for FY 2003 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been paid to long-term care hospitals under Part 413 of this subchapter without regard to the prospective payment system implemented under this subpart, excluding the effects of sections 1886(b)(2) and (b)(3) of the Act.

(3) *One-time prospective adjustment.* The Secretary will review payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates by October 1, 2006, so that the effect of any significant difference between actual payments and estimated payments for the first year of the long-term care hospital prospective payment system is not perpetuated in the prospective payment rates for future years.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, a long-term care hospital's Federal prospective payment is computed on the basis of the Federal prospective payment rate multiplied by the relative weight of the LTC-DRG assigned for that discharge. A hospital's Federal prospective payment rate will be adjusted, as appropriate, to account for outliers and other factors as specified in § 412.525.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34162, June 6, 2003]

#### § 412.525 Adjustments to the Federal prospective payment.

(a) *Adjustments for high-cost outliers.*

(1) CMS provides for an additional payment to a long-term care hospital if its estimated costs for a patient exceed the adjusted LTC-DRG payment plus a fixed-loss amount. For each long-term care hospital rate year, CMS determines a fixed-loss amount that is the maximum loss that a hospital can incur under the prospective payment system for a case with unusually high costs.

(2) The fixed-loss amount is determined for the long-term care hospital rate year using the LTC-DRG relative weights that are in effect on July 1 of the rate year.

(3) The additional payment equals 80 percent of the difference between the estimated cost of the patient care (determined by multiplying the hospital-specific cost-to-charge ratios by the Medicare allowable covered charge) and the sum of the adjusted Federal prospective payment for the LTC-DRG prospective payment system payment and the fixed-loss amount.

(4)(i) For discharges occurring on or after October 1, 2002 and before August 8, 2003, no reconciliations will be made to outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, high-cost outlier payments are subject to the provisions of §§ 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, high-cost outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(c) *Adjustments for area levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.62(f)(1)(ii) and (f)(1)(iii), respectively.

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(d) *Special payment provisions.* CMS adjusts the Federal prospective payment to account for—

(1) Short-stay outliers, as provided for in § 412.529; and

(2) Interruption of a stay, as provided for in § 412.531.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34163, June 6, 2003; 68 FR 34515, June 9, 2003]

### § 412.529 Special payment provision for short-stay outliers.

(a) *Short-stay outlier defined.* “Short-stay outlier” means a discharge with a length of stay in a long-term care hospital that is up to and including five-sixths of the geometric average length of stay for each LTC-DRG.

(b) *Adjustment to payment.* CMS adjusts the hospital’s Federal prospective payment to account for any case that is determined to be a short-stay outlier, as defined in paragraph (a) of this section, under the methodology specified in paragraph (c) of this section.

(c) *Method for determining the payment amount.* (1) Subject to the provisions of paragraph (c)(4) of this section, the adjusted payment amount for a short-stay outlier is the least of the following amounts:

(i) 120 percent of the LTC-DRG specific per diem amount determined under paragraph (c)(2) of this section multiplied by the length of stay of the discharge;

(ii) 120 percent of the cost of the case determined under paragraph (c)(3) of this section; or

(iii) The Federal prospective payment for the LTC-DRG.

(2) CMS calculates a per diem amount for short-stay outliers for each LTC-DRG by dividing the product of the standard Federal payment rate and the LTC-DRG weight by the geometric mean length of stay of the specific LTC-DRG.

(3) To determine the cost of a case, CMS uses the hospital-specific cost-to-charge ratio and the Medicare allowable charges for the case.

(4) Effective for discharges occurring on or after July 1, 2003, for long-term care hospitals described under § 412.23(e)(2)(ii), the adjusted payment amount for a short-stay outlier is de-

termined under the formula set forth in paragraph (c)(1) of this section with the following substitution of the percentages specified for the LTG-DRG specific per diem amount and the cost of the case under paragraphs (c)(1)(i) and (c)(1)(ii) of this section:

(i) For the 1st year of the transition period, as specified at § 412.533(a)(1), the percentage is 195 percent.

(ii) For the 2nd year of the transition period, as specified at § 412.533(a)(2), the percentage is 193 percent;

(iii) For the 3rd year of the transition period, as specified at § 412.533(a)(3), the percentage is 165 percent;

(iv) For the 4th year of the transition period, as specified at § 412.533(a)(4), the percentage is 136 percent;

(v) For the 5th year of the transition period and after, as specified at § 412.533(a)(5), the percentage is 120 percent.

(5)(i) For discharges occurring on or after October 1, 2002 and before August 8, 2003, no reconciliations will be made to short-stay outlier payments upon cost report settlement to account for differences between cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, short-stay outlier payments are subject to the provisions of §§ 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, short-stay outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34163, June 6, 2003; 68 FR 34515, June 9, 2003]

### § 412.531 Special payment provisions when an interruption of a stay occurs in a long-term care hospital.

(a) *Interruption of a stay defined.* “Interruption of a stay” means a stay at a long-term care hospital during which a Medicare inpatient is transferred upon discharge to an acute care hospital, an IRF, or a SNF for treatment or services that are not available in the long-term care hospital and returns to the same long-term care hospital within the applicable fixed day

period specified in paragraphs (a)(1) through (a)(3) of this section.

(1) For a discharge to an acute care hospital, the applicable fixed day period is 9 days. The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 9th day after the discharge.

(2) For a discharge to an IRF, the applicable fixed day period is 27 days. The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 27th day after the discharge.

(3) For a discharge to a SNF, the applicable fixed day period is 45 days. The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 45th day after the discharge.

(b) *Methods of determining payments.*

(1) For purposes of determining a Federal prospective payment, any stay in a long-term care hospital that involves an interruption of the stay will be paid as a single discharge from the long-term care hospital. The number of days that a beneficiary spends in an acute care hospital, an IRF, or a SNF during an interruption of stay at a long-term care hospital is not included in determining the length of stay of the patient at the long-term care hospital. CMS will make only one LTC-DRG payment for all portions of a long-term care stay that involves an interruption of a stay. In accordance with §412.513(b), payment will be based on the patient's LTC-DRG that would be determined by the principal diagnosis, which is the condition established after study to be chiefly responsible for occasioning the first admission of the patient to the hospital for care.

(2) If the total number of days of a patient's length of stay in a long-term care hospital prior to and following an interruption of a stay is up to and including five-sixths of the geometric average length of stay of the LTC-DRG, CMS will make a Federal prospective payment for a short-stay outlier in accordance with §412.529(c).

(3) If the total number of days of a patient's length of stay in a long-term care hospital prior to and following an interruption of a stay exceeds five-sixths of the geometric average length

of stay for the LTC-DRG, CMS will make one full Federal LTC-DRG prospective payment for the case. An additional payment will be made if the patient's stay qualifies as a high-cost outlier, as set forth in §412.525(a).

(4) Notwithstanding the provisions of paragraph (a) of this section, if a patient who has been discharged from a long-term care hospital to another facility and is readmitted to the long-term care hospital for additional treatment or services in the long-term care hospital following the stay at the other facility, the subsequent admission to the long-term care hospital is considered a new stay, even if the case is determined to fall into the same LTC-DRG, and the long-term care hospital will receive two separate Federal prospective payments if one of the following conditions are met:

(i) The patient has a length of stay in the acute care hospital that exceeds 9 days from the day of discharge from the long-term care hospital;

(ii) The patient has a length of stay in the IRF that exceeds 27 days from the day of discharge from the long-term care hospital; or

(iii) The patient has a length of stay in the SNF that exceeds 45 days from the day of discharge from the long-term care hospital.

(c) *Payments to an acute care hospital, an IRF, or a SNF during an interruption of a stay.*

(1) Payment to the acute care hospital for the acute care hospital stay following discharge from the long-term care hospital will be paid in accordance with the acute care hospital inpatient prospective payment systems specified in §412.1(a)(1).

(2) Payment to an IRF for the IRF stay following a discharge from the long-term care hospital will be paid in accordance with the IRF prospective payment system specified in §412.624 of Subpart P of this part.

(3) Payment to a SNF for the SNF stay following a discharge from the long-term care hospital will be paid in accordance with the SNF prospective payment system specified in subpart J of Part 413 of this subchapter.



**§ 412.532 Special payment provisions for patients who are transferred to onsite providers and readmitted to a long-term care hospital.**

(a) The policies set forth in this section apply in the following situations:

(1) A long-term care hospital (including a satellite facility) that is co-located within an onsite acute care hospital, an onsite IRF, or an onsite psychiatric facility or unit that meets the definition of a hospital-within-a-hospital under § 412.22(e).

(2) A satellite facility, as defined in § 412.22(f), that is co-located with the long-term care hospital.

(3) A SNF, as defined in section 1819(a) of the Act, that is co-located with the long-term care hospital.

(b) As used in this section, “co-located” or “onsite” facility means a hospital or unit that occupies space in a building also used by another hospital or unit or in one or more buildings on the same campus, as defined in § 413.65(a)(2) of this subchapter, as buildings used by another hospital or unit.

(c) If, during a cost reporting period, a long-term care hospital (including a satellite facility) discharges patients to an acute care hospital co-located with the long-term care hospital, as described in paragraph (a) of this section, and subsequently directly readmits more than 5 percent (that is, in excess of 5.0 percent) of the total number of its Medicare inpatients discharged from that acute care hospital, all such discharges to the co-located acute care hospital and the readmissions to the long-term care hospital will be treated as one discharge for that cost reporting period and one LTC-DRG payment will be made on the basis of each patient’s initial principal diagnosis.

(d) If, during a cost reporting period, a long-term care hospital (including a satellite facility) discharges patients to an onsite IRF, an onsite psychiatric hospital or unit, or an onsite SNF, as described in paragraph (a) of this section, and subsequently directly readmits more than 5 percent (that is, in excess of 5.0 percent) of the total number of its Medicare inpatients discharged from the onsite IRF, the onsite psychiatric hospital or unit, or the onsite SNF, all such discharges to any of

these providers and the readmissions to the LTCH will be treated as one discharge for that cost reporting period and one LTC-DRG payment will be made on the basis of the patient’s initial principal diagnosis.

(e) For purposes of calculating the payment per discharge, payment for the entire stay at the long-term care hospital will be paid as a full LTC-DRG payment under § 412.523 or a short-stay outlier under § 412.529, depending on the duration of the entire stay.

(f) If the long-term care hospital does not meet the 5-percent thresholds specified under paragraph (c) or (d) of this section for discharges to the specified onsite providers and readmissions to the long-term care hospital during a cost reporting period, payment under the long-term care prospective payment system will be made, where applicable, under the policies on interruption of a stay as specified in § 412.531.

(g) Payment to the onsite acute care hospital, the onsite IRF, the onsite psychiatric hospital or unit, and the onsite SNF for a beneficiary’s stay in the specified onsite providers is subject to the applicable payment policies, including outliers and transfers, under the acute care hospital inpatient prospective payment system, the IRF prospective payment system, the SNF prospective payment system, or the excluded psychiatric hospital or unit cost-based reimbursement payment system, as appropriate.

(h) In determining whether a patient has previously been discharged and then admitted, all prior discharges are considered, even if the discharge occurs late in one cost reporting period and the readmission occurs late in next cost reporting period.

(i) A long-term care hospital or a satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(4) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days following the effective date of these regulations and within 60 days of a change in this co-located status.

**§412.533 Transition payments.**

(a) *Duration of transition periods.* Except for a long-term care hospital that makes an election under paragraph (c) of this section or for a long-term care hospital that is defined as new under §412.23(e)(4), for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, a long-term care hospital receives a payment comprised of a blend of the adjusted Federal prospective payment as determined under §412.523, and the payment determined under the cost-based reimbursement rules under Part 413 of this subchapter.

(1) For cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003, payment is based on 20 percent of the Federal prospective payment rate and 80 percent of the cost-based reimbursement rate.

(2) For cost reporting periods beginning on or after October 1, 2003 and before October 1, 2004, payment is based on 40 percent of the Federal prospective payment rate and 60 percent of the cost-based reimbursement rate.

(3) For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005, payment is based on 60 percent of the Federal prospective payment rate and 40 percent of the cost-based reimbursement rate.

(4) For cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006, payment is based on 80 percent of the Federal prospective payment rate and 20 percent of the cost-based reimbursement rate.

(5) For cost reporting periods beginning on or after October 1, 2006, payment is based entirely on the adjusted Federal prospective payment rate.

(b) *Adjustments based on reconciliation of cost reports.* The cost-based percentage of the provider's total Medicare payment under paragraphs (a)(1) through (a)(4) of this section are subject to adjustments based on reconciliation of cost reports.

(c) *Election not to be paid under the transition period methodology.* A long-term care hospital may elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition periods specified in paragraph (a) of this section. Once a

long-term care hospital elects to be paid based on 100 percent of the Federal prospective payment rate, it may not revert to the transition blend.

(1) *General requirement.* A long-term care hospital must notify its fiscal intermediary of its intent to elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period specified in paragraph (a) of this section.

(2) *Notification requirement to make election.*

(i) The request by the long-term care hospital to make the election under paragraph (c)(1) of this section must be made in writing to the Medicare fiscal intermediary.

(ii) For cost reporting periods that begin on or after October 1, 2002 through November 30, 2002, the fiscal intermediary must receive the notification of the election before November 1, 2002.

(iii) For cost reporting periods that begin on or after December 1, 2002 through September 30, 2006, the fiscal intermediary must receive the notification of the election on or before the 30th day before the applicable cost reporting period begins.

(iv) The fiscal intermediary must receive the notification by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section will not be accepted. If the date specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section falls on a day that the postal service or other delivery sources are not open for business, the long-term care hospital is responsible for allowing sufficient time for the delivery of the notification before the deadline.

(v) If a long-term care hospital's notification is not received by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, payment will be based on the transition period rates specified in paragraphs (a)(1) through (a)(5) of this section.

(d) *Payments to new long-term care hospitals.* A new long-term care hospital, as defined in §412.23(e)(4), will be paid

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based on 100 percent of the standard Federal rate, as described in § 412.523, with no transition payments, as described in § 412.533(a)(1) through (a)(5).

##### **§ 412.535 Publication of the Federal prospective payment rates.**

CMS publishes information pertaining to the long-term care hospital prospective payment system effective for each annual update in the FEDERAL REGISTER.

(a) Information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the start of each long-term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1.

(b) Information on the LTC-DRG classification and associated weighting factors is published on or before August 1 prior to the beginning of each Federal fiscal year.

[68 FR 34163, June 6, 2003]

##### **§ 412.541 Method of payment under the long-term care hospital prospective payment system.**

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, long-term care hospitals receive payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments.*

(1) *Criteria for receiving periodic interim payments.*

(i) A long-term care hospital receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the long-term care hospital must meet the qualifying requirements in § 413.64(h)(3) of this subchapter.

(iii) As provided in § 413.64(h)(5) of this subchapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method

without undue risk of the PIP resulting in an overpayment to the provider.

(2) *Frequency of payment.*

(i) For long-term care hospitals approved for PIP and paid solely under Federal prospective payment system rates under § 412.533(b), the intermediary estimates the long-term care hospital's Federal prospective payments net after estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to  $\frac{1}{26}$  of the total estimated amount of payment for the year.

(ii) For long-term care hospitals approved for PIP and paid using the blended payment schedule specified in § 412.533(a) for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, the intermediary estimates the hospital's portion of the Federal prospective payments net and the hospital's portion of the reasonable cost-based reimbursement payments net, after beneficiary deductibles and coinsurance, in accordance with the blended transition percentages specified in § 412.533(a), and makes biweekly payments equal to  $\frac{1}{26}$  of the total estimated amount of both portions of payments for the year.

(iii) If the long-term care hospital has payment experience under the long-term care hospital prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year.

(iv) Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this subchapter.

(v) The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the hospital.* Subject to paragraph (b)(1)(iii) of this section, a long-term care hospital receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the

long-term care hospital no longer meets the requirements of §413.64(h) of this subchapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for the costs of an approved education program, blood clotting factors, anesthesia services furnished by hospital-employed non-physician anesthetists or obtained under arrangement, and photocopying and mailing medical records to a QIO, which are costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to  $\frac{1}{26}$  of the total estimated amount. Each payment is made 2 weeks after the end of the biweekly period of service as described in §413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a long-term care hospital receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Special interim payment for unusually long lengths of stay.*

(1) *First interim payment.* A hospital that is not receiving periodic interim payments under paragraph (b) of this section may request an interim payment 60 days after a Medicare beneficiary has been admitted to the hospital. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

(2) *Additional interim payments.* A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment

made under the provisions of this paragraph.

(e) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(f) *Accelerated payments.* (1) *General rule.* Upon request, an accelerated payment may be made to a long-term care hospital that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the long-term care hospital.

(ii) Due to an exceptional situation, there is a temporary delay in the hospital's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* A request by a long-term care hospital for an accelerated payment must be approved by the intermediary and by CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as long-term care hospital bills are processed or by direct payment by the long-term care hospital.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 10988, Mar. 7, 2003]

## Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

SOURCE: 66 FR 41388, Aug. 7, 2001, unless otherwise noted.

### §412.600 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as "inpatient rehabilitation facilities").

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(b) *Scope.* This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2002, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined rates and applied on a per discharge basis.

### § 412.602 Definitions.

As used in this subpart—

*Assessment reference date* means the specific calendar day in the patient assessment process that sets the designated endpoint of the common patient observation period, with most patient assessment items usually referring back in time from this endpoint.

*CMS* stands for the Centers for Medicare & Medicaid Services.

*Comorbidity* means a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay.

*Discharge.* A Medicare patient in an inpatient rehabilitation facility is considered discharged when—

(1) The patient is formally released from the inpatient rehabilitation facility; or

(2) The patient dies in the inpatient rehabilitation facility.

*Encode* means entering data items into the fields of the computerized patient assessment software program.

*Functional-related groups* refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

*Interrupted stay* means a stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of the stay of 3 consecutive calendar days begins with

the day of discharge from the inpatient rehabilitation facility and ends on midnight of the third day.

*Outlier payment* means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

*Patient assessment instrument* refers to a document that contains clinical, demographic, and other information on a patient.

*Rural area* means an area as defined in § 412.62(f)(1)(iii).

*Transfer* means the release of a Medicare inpatient from an inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term, acute-care prospective payment hospital, a long-term care hospital as described in § 412.23(e), or a nursing home that qualifies to receive Medicare or Medicaid payments.

*Urban area* means an area as defined in § 412.62(f)(1)(ii).

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003]

### § 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

(a) *General requirements.* (1) Effective for cost reporting periods beginning on or after January 1, 2002, an inpatient rehabilitation facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(2) If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare Part A fee-for-service beneficiaries, CMS or its Medicare fiscal intermediary may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient rehabilitation facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient rehabilitation facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the

prospective payment systems specified in §412.1(a)(1).

(b) *Inpatient rehabilitation facilities subject to the prospective payment system.* Subject to the special payment provisions of §412.22(c), an inpatient rehabilitation facility must meet the general criteria set forth in §412.22 and the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in §§412.23(b), 412.25, and 412.29 for exclusion from the inpatient hospital prospective payment systems specified in §412.1(a)(1).

(c) *Completion of patient assessment instrument.* For each Medicare Part A fee-for-service patient admitted to or discharged from an IRF on or after January 1, 2002, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with §412.606.

(d) *Limitation on charges to beneficiaries—(1) Prohibited charges.* Except as provided in paragraph (d)(2) of this section, an inpatient rehabilitation facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient rehabilitation facility receiving payment under this subpart for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§409.82, 409.83, and 409.87 of this subchapter and for items or services as specified under §489.20(a) of this chapter.

(e) *Furnishing of inpatient hospital services directly or under arrangement.* (1) Subject to the provisions of §412.622(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in §409.10 of this subchapter. Inpatient hospital services do not include the following:

(i) Physicians' services that meet the requirements of §415.102(a) of this subchapter for payment on a fee schedule basis.

(ii) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(iii) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(v) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(vi) Services of an anesthetist, as defined in §410.69 of this chapter.

(2) Medicare does not pay any provider or supplier other than the inpatient rehabilitation facility for services furnished to a Medicare beneficiary who is an inpatient of the inpatient rehabilitation facility, except for services described in paragraphs (e)(1)(i) through (e)(1)(vi) of this section.

(3) The inpatient rehabilitation facility must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements (as defined in §409.3 of this subchapter).

(f) *Reporting and recordkeeping requirements.* All inpatient rehabilitation facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§413.20 and 413.24 of this subchapter.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003]

#### §412.606 Patient assessments.

(a) *Admission orders.* At the time that each Medicare Part A fee-for-service patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized.

(b) *Patient assessment instrument.* An inpatient rehabilitation facility must use the CMS inpatient rehabilitation facility patient assessment instrument to assess Medicare Part A fee-for-service inpatients who—

(1) Are admitted on or after January 1, 2002; or

(2) Were admitted before January 1, 2002, and are still inpatients as of January 1, 2002.

(c) *Comprehensive assessments.* (1) A clinician of the inpatient rehabilitation facility must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare Part A fee-for-service inpatient using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of this section as part of his or her patient assessment in accordance with the schedule described in § 412.610.

(2) A clinician employed or contracted by an inpatient rehabilitation facility who is trained on how to perform a patient assessment using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of the section must record appropriate and applicable data accurately and completely for each item on the patient assessment instrument.

(3) The assessment process must include—

(i) Direct patient observation and communication with the patient; and

(ii) When appropriate and to the extent feasible, patient data from the patient's physician(s), family, someone personally knowledgeable about the patient's clinical condition or capabilities, the patient's clinical record, and other sources.

**§ 412.608 Patients' rights regarding the collection of patient assessment data.**

(a) Before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient—

(1) The form entitled "Privacy Act Statement—Health Care Records"; and

(2) The simplified plain language description of the Privacy Act Statement—Health Care Records which is a form entitled "Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities."

(b) The inpatient rehabilitation facility must document in the Medicare inpatient's clinical record that the Medicare inpatient has been given the documents specified in paragraph (a) of this section.

(c) By giving the Medicare inpatient the forms specified in paragraph (a) of this section the inpatient rehabilitation facility will inform the Medicare patient of—

(1) Their privacy rights under the Privacy Act of 1974 and 45 CFR 5b.4(a)(3); and

(2) The following rights:

(i) The right to be informed of the purpose of the collection of the patient assessment data;

(ii) The right to have the patient assessment information collected be kept confidential and secure;

(iii) The right to be informed that the patient assessment information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(iv) The right to refuse to answer patient assessment questions; and

(v) The right to see, review, and request changes on his or her patient assessment.

(d) The patient rights specified in this section are in addition to the patient rights specified in § 82.13 of this chapter.

[68 FR 45699, Aug. 1, 2003]

**§ 412.610 Assessment schedule.**

(a) *General.* For each Medicare Part A fee-for-service inpatient, an inpatient rehabilitation facility must complete a patient assessment instrument as specified in § 412.606 that covers a time period that is in accordance with the assessment schedule specified in paragraph (c) of this section.

(b) *Starting the assessment schedule day count.* The first day that the Medicare Part A fee-for-service inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the patient assessment schedule.

(c) *Assessment schedules and reference dates.* The inpatient rehabilitation facility must complete a patient assessment instrument upon the Medicare Part A fee-for-service patient's admission and discharge as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) *Admission assessment.*

(i) *General rule.* The admission assessment—

(A) Time period is a span of time that covers calendar days 1 through 3 of the patient's current Medicare Part A fee-for-service hospitalization;

(B) Has an admission assessment reference date that is the third calendar day of the span of time specified in paragraph (c)(1)(i)(A) of this section; and

(C) Must be completed by the calendar day that follows the admission assessment reference day.

(ii) *Exception to the general rule.* We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different admission assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(2) *Discharge assessment.*

(i) *General rule.* The discharge assessment—

(A) Time period is a span of time that covers 3 calendar days, and is the discharge assessment reference date itself specified in paragraph (c)(2)(ii) of this section and the 2 calendar days prior to the discharge assessment reference date; and

(B) Must be completed on the 5th calendar day that follows the discharge assessment reference date specified in paragraph (c)(2)(ii) of this section with the discharge assessment reference date itself being counted as the first day of the 5 calendar day time span.

(ii) *Discharge assessment reference date.* The discharge assessment reference date is the actual day that the first of either of the following two events occurs:

(A) The patient is discharged from the inpatient rehabilitation facility; or

(B) The patient stops being furnished Medicare Part A fee-for-service inpatient rehabilitation services.

(iii) *Exception to the general rule.* We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different discharge assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(d) *Encoding dates.* The admission and discharge patient assessments must be encoded by the 7th calendar day from the completion dates specified in paragraph (c) of this section.

(e) *Accuracy of the patient assessment data.* The encoded patient assessment data must accurately reflect the patient's clinical status at the time of the patient assessment.

(f) *Patient assessment instrument record retention.* An inpatient rehabilitation facility must maintain all patient assessment data sets completed on Medicare Part A fee-for-service patients within the previous 5 years either in a paper format in the patient's clinical record or in an electronic computer file format that the inpatient rehabilitation facility can easily obtain.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003]

**§412.612 Coordination of the collection of patient assessment data.**

(a) *Responsibilities of the clinician.* A clinician of an inpatient rehabilitation facility who has participated in performing the patient assessment must have responsibility for—

(1) The accuracy and thoroughness of the specific data recorded by that clinician on the patient's assessment instrument; and

(2) The accuracy of the assessment reference date inserted on the patient assessment instrument completed under §412.610(c).

(b) *Penalty for falsification.*

(1) Under Medicare, an individual who knowingly and willfully—

(i) Completes a material and false statement in a patient assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or

(ii) Causes another individual to complete a material and false statement in a patient assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.



**§412.614 Transmission of patient assessment data.**

(a) *Data format. General rule.* The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service inpatient—

(1) Using the computerized version of the patient assessment instrument available from us; or

(2) Using a computer program(s) that conforms to our standard electronic record layout, data specifications, and data dictionary, includes the required patient assessment instrument data set, and meets our other specifications.

(3) *Exception to the general rule.* When the inpatient rehabilitation facility does not submit claim data to Medicare in order to be paid for any of the services it furnished to a Medicare Part A fee-for-service inpatient, the inpatient rehabilitation facility is not required to, but may, transmit to Medicare the inpatient rehabilitation facility patient assessment data associated with the services furnished to that same Medicare Part A fee-for-service inpatient.

(b) *How to transmit data.* The inpatient rehabilitation facility must—

(1) Electronically transmit complete, accurate, and encoded data from the patient assessment instrument for each Medicare Part A fee-for-service inpatient to our patient data system in accordance with the data format specified in paragraph (a) of this section; and

(2) Transmit data using electronic communications software that provides a direct telephone connection from the inpatient rehabilitation facility to the our patient data system.

(c) *Transmission dates.* The inpatient rehabilitation facility must transmit both the admission patient assessment and the discharge patient assessments at the same time to the our patient data system by the 7th calendar day in the period beginning with the applicable patient assessment instrument encoding date specified in §412.610(d).

(d) *Late transmission penalty.* (1) We assess a penalty when an inpatient rehabilitation facility does not transmit the required data from the patient assessment instrument to the our patient data system in accordance with the

transmission timeframe in paragraph (c) of this section.

(2) If the actual patient assessment data transmission date is later than 10 calendar days from the transmission date specified in paragraph (c) of this section, the patient assessment data is considered late and the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

(e) *Exemption to being assessed a penalty for transmitting the IRF-PAI data late.* CMS may waive the penalty specified in paragraph (d) of this section when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data in accordance with paragraph (c) of this section. Only CMS can determine if a situation encountered by an inpatient rehabilitation facility is extraordinary and qualifies as a situation for waiver of the penalty specified in paragraph (d)(2) of this section. An extraordinary situation may be due to, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflict extensive damage to an inpatient rehabilitation facility. An extraordinary situation may be one that produces a data transmission problem that is beyond the control of the inpatient rehabilitation facility, as well as other situations determined by CMS to be beyond the control of the inpatient rehabilitation facility. An extraordinary situation must be fully documented by the inpatient rehabilitation facility.

[66 FR 41388, Aug. 7, 2001, as amended at 68 FR 45699, Aug. 1, 2003]

**§412.616 Release of information collected using the patient assessment instrument.**

(a) *General.* An inpatient rehabilitation facility may release information from the patient assessment instrument only as specified in §482.24(b)(3) of this chapter.

(b) *Release to the inpatient rehabilitation facility's agent.* An inpatient rehabilitation facility may release information that is patient-identifiable to an

agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and only to the extent the facility itself is permitted to do so under paragraph (a) of this section.

**§ 412.618 Assessment process for interrupted stays.**

For purposes of the patient assessment process, if a Medicare Part A fee-for-service patient has an interrupted stay, as defined under § 412.602, the following applies:

(a) *Assessment requirements.* (1) The initial case-mix group classification from the admission assessment remains in effect (that is, no new admission assessment is performed).

(2) When the patient has completed his or her entire rehabilitation episode stay, a discharge assessment must be performed.

(b) *Recording and encoding of data.* The clinician must record the interruption of the stay on the patient assessment instrument.

(c) If the interruption in the stay occurs during the admission assessment time period, the assessment reference date, completion date, and encoding date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002]

**§ 412.620 Patient classification system.**

(a) *Classification methodology.*

(1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from admission assessments under § 412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(4) Data from the discharge assessment under § 412.610(c)(2) are used to determine the weighting factors under paragraph (b)(4) of this section.

(b) *Weighting factors.*

(1) *General.* An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) *Short-stay outliers.* We will determine a weighting factor or factors for patients that are discharged and not transferred (as defined in § 412.602) within a number of days from admission as specified by us.

(3) *Patients who expire.* We will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by us.

(4) *Comorbidities.* We will determine a weighting factor or factors to account for the presence of a comorbidity, as defined in § 412.602, that is relevant to resource use in the classification system.

(c) *Revision of case-mix group classifications and weighting factors.* We may periodically adjust the case-mix groups and weighting factors to reflect changes in—

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of resources.

**§ 412.622 Basis of payment.**

(a) *Method of payment.*

(1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in § 412.624 and, if applicable, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in § 412.626.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and

capital-related costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§ 413.85 and 413.86 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following:

(i) Bad debts of Medicare beneficiaries, as provided in § 413.80 of this chapter; and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

**§ 412.624 Methodology for calculating the Federal prospective payment rates.**

(a) *Data used.* To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities, we use—

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, to estimate payments for inpatient operating and capital-related costs made under part 413 of this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient rehabilitation services; and

(4) Patient assessment data described in § 412.606 and other data that account for the relative resource utilization of different patient types.

(b) *Determining the average costs per discharge for fiscal year 2001.* We determine the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data specified under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2001 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2001.

(c) *Determining the Federal prospective payment rates—*(1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard payment conversion factor. The standard payment conversion factor is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments, and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, CMS estimates the payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the standard payment conversion factor.* The standard payment conversion factor is computed as follows:

(i) *For fiscal year 2002.* Based on the updated costs per discharge and estimated payments for fiscal year 2002 determined in paragraph (c)(2) of this section, CMS computes a standard payment conversion factor for fiscal year 2002, as specified by CMS, that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The standard payment conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(4) *Determining the Federal prospective payment rate for each case-mix group.* The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in § 412.620(b) and the standard payment conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard payment conversion factor.* The standard payment conversion factor described in

paragraph (c)(3) of this section will be adjusted for the following:

(1) *Outlier payments.* CMS determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(4) of this section.

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for fiscal year 2002 so that aggregate payments under the prospective payment system, excluding any additional payments associated with elections not to be paid under the transition period methodology under §412.626(b), are estimated to equal the amount that would have been made to inpatient rehabilitation facilities under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Coding and classification changes.* CMS adjusts the standard payment conversion factor for a given year if CMS determines that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that those revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate that is in effect for its cost reporting period that begins in a Federal fiscal year specified under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) *Adjustment for area wage levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in §412.602. Adjustments or updates to the wage data used to adjust a facility's Federal pro-

spective payment rate under paragraph (e)(1) of this section will be made in a budget neutral manner. CMS determines a budget neutral wage adjustment factor, based on any adjustment or update to the wage data, to apply to the standard payment conversion factor.

(2) *Adjustments for low-income patients.* We adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us.

(3) *Adjustments for rural areas.* We adjust the Federal prospective payment by a factor, as specified by us for facilities located in rural areas, as defined in §412.602.

(4) *Adjustment for high-cost outliers.* CMS provides for an additional payment to an inpatient rehabilitation facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients and for rural locations) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at §412.84(i), except that national averages will be used instead of statewide averages. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at §412.84(m).

(5) *Adjustments related to the patient assessment instrument.* An adjustment to a facility's Federal prospective payment amount for a given discharge will be made, as specified under §412.614(d), if the transmission of data from a patient assessment instrument is late.

(f) *Special payment provision for patients that are transferred.*

(1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who—

(i) Is transferred from the inpatient rehabilitation facility to another site of care, as defined in §412.602; and

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(ii) Stays in the facility for a number of days that is less than the average length of stay for nontransfer cases in the case-mix group to which the patient is classified.

(2) We calculate the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for nontransfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the per day payment amount.

(iii) By multiplying the payment per day under paragraph (f)(2)(i) by 0.5 to equal an additional one half day payment for the first day of the stay before the discharge.

(iv) By adding the per day payment amount under paragraph (f)(2)(ii) and the additional one-half day payment under paragraph (f)(2)(iii) to equal the unadjusted payment amount.

(v) By applying the adjustments described in paragraphs (e)(1), (e)(2), and (e)(3) of this section to the unadjusted payment amount determined in paragraph (f)(2)(iv) of this section to equal the adjusted transfer payment amount.

(g) *Special payment provision for interrupted stays.* When a patient in an inpatient rehabilitation facility has one or more interruptions in the stay, as defined in § 412.602 and as indicated on the patient assessment instrument in accordance with § 412.618(b), we will make payments in the following manner:

(1) *Patient is discharged and returns on the same day.* Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will be the adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in § 412.618(a)(1). Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will only be made to the inpatient rehabilitation facility.

(2) *Patient is discharged and does not return by the end of the same day.* Payment for a patient who is discharged and does not return on the same day but does return to the same inpatient rehabilitation facility by or on midnight of the third day, defined as an interrupted stay under § 412.602, will be—

(i) The adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in § 412.618(a)(1) made to the inpatient rehabilitation facility; and

(ii) If the reason for the interrupted patient stay is to receive inpatient acute care hospital services, an amount based on the prospective payment systems described in § 412.1(a)(1) made to the acute care hospital.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 45700, Aug. 1, 2003]

**§ 412.626 Transition period.**

(a) *Duration of transition period and proportion of the blended transition rate.*

(1) Except for a facility that makes an election under paragraph (b) of this section, for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, an inpatient rehabilitation facility receives a payment comprised of a blend of the adjusted Federal prospective payment, as determined under § 412.624(e) or § 412.624(f) and a facility-specific payment as determined under paragraph (a)(2) of this section.

(i) For cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, payment is based on 33⅓ percent of the facility-specific payment and 66⅔ percent of the adjusted FY 2002 Federal prospective payment.

(ii) For cost reporting periods beginning on or after October 1, 2002, payment is based entirely on the adjusted Federal prospective payment.

(2) *Calculation of the facility-specific payment.* The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment

for inpatient operating costs and capital-related costs in accordance with part 413 of this chapter.

(b) *Election not to be paid under the transition period methodology.* An inpatient rehabilitation facility may elect a payment that is based entirely on the adjusted Federal prospective payment for cost reporting periods beginning before fiscal year 2003 without regard to the transition period percentages specified in paragraph (a)(1)(i) of this section.

(1) *General requirement.* An inpatient rehabilitation facility will be required to request the election under this paragraph (b) within 30 days of its first cost reporting period for which payment is based on the inpatient rehabilitation facility prospective payment system for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

(2) *Notification requirement to make election.* The request by the inpatient rehabilitation facility to make the election under this paragraph (b) must be made in writing to the Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before the cost reporting period begins falls on a day that the postal service or other delivery sources are not open for business, the inpatient rehabilitation facility is responsible for allowing sufficient time for the delivery of the request before the deadline. If an inpatient rehabilitation facility's request is not received timely or is otherwise not approved, payment will be based on the transition period rate specified in paragraph (a)(1)(i) of this section.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002]

**§412.628 Publication of the Federal prospective payment rates.**

We publish information pertaining to the inpatient rehabilitation facility prospective payment system effective for each fiscal year in the FEDERAL

REGISTER. This information includes the unadjusted Federal payment rates, the patient classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

**§412.630 Limitation on review.**

Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

**§412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.**

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient rehabilitation facility receives payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments.*

(1) *Criteria for receiving periodic interim payments.*

(i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of §413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in §413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in §412.116.

(iv) As provided in §413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the inpatient rehabilitation facility.* Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of §413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this chapter. The interim payments are reviewed at

least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) *Accelerated payments.* (1) *General rule.* Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and us.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

## **PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES**

### **Subpart A—Introduction and General Rules**

#### **Sec.**

#### **413.1 Introduction.**

#### **413.5 Cost reimbursement: General.**